Carol Breeding Arvin, M.A.

Confidential Client Intake Summary

Name_____ Date_____

Address_____City/state/zip_____

Cell phone_____ OK to leave message? YES NO

Other phone (type)_____ OK to leave message? YES NO

Email_____ OK to leave message? YES NO

Age:_____ Date of birth:_____

Employer (or school, if student)_____ Occupation_____

Marital/legal status (circle one): Single Partnered Married Separated Divorced Widowed

Others living in home: name, relationship, and age_____

_____

Emergency contact_____Relationship_____Phone_____

Referred by/from_____ Physician_____

Brief description of why you're seeking counseling:_____

_____

Previous counseling history: approximately how many visits with a therapist?

1-4 5-10 11-30 1 year or more 2 years or more

How was previous therapy helpful or not helpful?_____
_____

Current medications/dosage_____

Previous medications, dosages, dates, reasons discontinued_____
_____

Family History

Raised by/lived with_____
Place(s) raised_____

Religious background_____ Cultural background_____

Family issues (of people other than you.) Please indicate who and when:

Alcohol abuse_____
Depression_____
Other mental illness_____
Adoption_____
Suicide_____
Learning problems_____
Parental violence_____
Physical abuse_____
Rape_____
Active combat_____
Work problems_____
Legal problems_____

Drug abuse_____
Anxiety or panic_____
Disability_____
Foster care_____
Other deaths_____
Health problems_____
Divorce/Separation_____
Sexual abuse_____
Imprisonment_____
Natural disaster_____
Relationship problems_____
Financial problems_____

Other problems or trauma; other information or more information about above:

Personal History

Earliest childhood memory or dream_____
_____

Most recent night dream_____
_____

Developmental and Educational History

Prenatal, birth, and infancy concerns:_____

Childhood illnesses:_____

Education history/highest level compleed:_____

Learning/school problems:_____

Comments:

History of trauma or abuse

Neglect/Physical abuse/Sexual abuse_____

_____

Rape or assault_____

Accidents/natural disasters/childhood losses_____

Comments:

Substance Use
Alcohol use (how much/how often) past_____present_____
Drug use (what/how much/how often) past_____present_____
Alcohol problem?_____ Drug problem?_____
Alcohol or drug problem in family?_____
Nicotine use (how much/how often) past_____present_____
Caffeine use (how much/how often)_____
Comments:

Work History
Current job:_____
Previous jobs:_____
Comments:

Religious/Spiritual History
Childhood_____ Current_____
Comments:

Marital History_____

Health Status

Describe current health problems/concerns:_____

_____

Current treatment:_____

_____

History of significant accidents/injuries (body/head) seizures, loss of consciousness, chronic health conditions, or chronic pain:_____

_____

Past psychiatric history: dates, physician, diagnosis, outcome_____

_____

Rate your overall health: excellent, good, fair, poor Do you exercise regularly? Yes/no
If yes, what types of exercise and how often?_____

Sources of help—people, groups, spiritual, etc._____

Please check any of the following that apply at this time:

___Anxiety/worry
___Panic attacks
___Fear
___Restlessness
___Anger
___Frustration
___Confusion
___Shyness
___Feeling inadequate
___Disorganized
___Difficulty making decisions
___Stress
___Loneliness
___Guilt
___Shame
___General unhappiness
___Depression
___Grief
___Crying spells
___Boredom
___Mood swings
___Suicidal thoughts
___Thoughts of hurting others
___Unwanted thoughts/rituals
___Problems at work
___Relationship problems
___Concern about sexual identity/preference
___Concern about sexual function
___Financial concerns
___Memory lapses, blank periods
___Unable to concentrate
___Headaches
___Aches or pains
___Abdominal problems
___Fatigue
___Low energy
___Nightmares
___Unwanted memories or images
___Cutting, burning or other self-harm
___Sudden impulses
___Difficulty coping with daily demands
___Difficulty trusting other
___Secrets I'm afraid to tell
___Physical problems or pain
___Disturbing fears
___Communication difficulties
___Inability to stop doing certain things
___Hearing voices/things others don't hear
___Depending too much on others
___Peculiar or weird experiences
___Feeling different from others
___Alcohol or drug abuse problem
___Restrict food
___Binge/purge food
___Use laxatives/exercise to control weight
___Other:_____

Recent changes in sleep patterns (#hrs more/less than usual):_____
Recent weight change (how many lbs. +/-):_____

What I hope from therapy is:_____

What I fear about therapy is:_____

What I most want my therapist to do is:_____

One question I would like you to answer is:_____

Something else I would like you to know is:_____

Personal strengths_____

and challenges_____

Thank you for taking the time to fill this out!

(Last update: 10/1/18)