

Carol Breeding Arvin, M.A.
Confidential Client Intake Summary

Name _____ Date _____

Address _____ City/state/zip _____

Cell phone _____ OK to leave message? YES NO

Home phone _____ OK to leave message? YES NO

Work phone _____ OK to leave message? YES NO

Email _____ OK to leave message? YES NO

Age: _____ Date of birth: _____ SS# _____

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 _____

Parents or guardian, if child _____

Who has primary custody, if child _____

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. Please indicate who and when:

Alcohol abuse _____	Drug abuse _____
Depression _____	Anxiety or panic _____
Other mental illness _____	Disability _____
Adoption _____	Foster care _____
Suicide _____	Other deaths _____
Learning problems _____	Health problems _____
Parental violence _____	Divorce/Separation _____
Physical abuse _____	Sexual abuse _____
Rape _____	Imprisonment _____
Active combat _____	Natural disaster _____
Work problems _____	Relationship problems _____
Legal 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
completed: _____

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:

- 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 wierd experiences
- Feeling different from others
- Alcohol or drug abuse problem
- Restrict food
- Binge/purge food
- Use laxatives/exercise to control weight

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!