CLIENT INTAKE

Kelly Peck Counseling, LLC

Please complete this form as it pertains to the client.

Why are you here today? _____

How long has this been going on? ☐ less than 6 months ☐ more than 6 months

Are you experiencing any of the following symptoms?

Depressive Symptoms: ☐ **NA**

☐ Depressed/irritable mood ☐ Poor appetite ☐ Anhedonia (lost of interest) ☐ Excessive weight gain
☐ Excessive weight loss ☐ Hopelessness ☐ Isolative ☐ Agitation
☐ Early Insomnia ☐ Mid Insomnia ☐ Early AM Awaking ☐ Hypersomnia (over-sleeping)
☐ Low Energy ☐ Poor Concentration ☐ Poor Memory ☐ Indecisiveness
☐ Recurring thoughts of death ☐ Suicidal ideation ☐ Excessive feelings of guilt ☐ Feelings of worthlessness
☐ Psychomotor retardation ☐ Excessive somatic complaints Other: _____

Anxiety Symptoms: ☐ **NA**

☐ Anxious mood ☐ Excess worry/rumination ☐ Restlessness/hyperactive ☐ Panic attacks ☐ Agoraphobia ☐ Poor Concentration
☐ Irritability ☐ Phobia, type: _____ Other: _____
☐ Past/current trauma ☐ Flashbacks ☐ Jumpy/easily startled ☐ ☐ Nightmares ☐ Avoiding distressing thoughts/memories

Other:

☐ Relational/Social problems ☐ Occupational problems ☐ Inattentiveness/ADHD
☐ Emotional/Verbal abuse ☐ Job stress ☐ Anger Control problems
☐ Physical abuse ☐ School problems ☐ Aggression/ self-regulation problems

☐ Abnormal fears ☐ Grief/Loss ☐ Elevated/Manic mood ☐ Hallucinations
☐ Negative cognitions ☐ Medical/health Issues ☐ Impulse control problems ☐ Delusions
☐ Irrational cognitions ☐ Life/Transition issues ☐ Thoughts of harming other ☐ Paranoid

Previous Psychiatric History

Have you received mental health services before? ☐ No ☐ Yes ☐ Voluntary ☐ Involuntary If yes, where and when:

Have you ever had a psychiatric hospitalization? ☐ No ☐ Yes ☐ Voluntary ☐ Involuntary If yes, where and when:

Is there a family history of psychiatric problems? ☐ No ☐ Yes If yes, please explain:

Medical Information

Do you have any current medical problems? (Please list): _____

Who is your current medical provider: _____ Telephone #: ( )

Would you like me to contact your medical provider regarding your presence in treatment? ☐ Yes ☐ No

Client Name: First MI Last	**Client ID #:**
Intake	Date:

Please list all current medications (including non-traditional medications i.e., herbs, vitamins, over-the-counter, other):

Medication Name	Dosage/Time	Reason	Prescriber	Currently Taking?
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

Substance Use: ☐ **N/A**

☐ Caffeine: Amount: _____ Frequency: _____ Duration: _____

☐ Tobacco: Amount: _____ Frequency: _____ Duration: _____

☐ Alcohol: Amount: _____ Frequency: _____ Duration: _____ Type: _____

☐ Marijuana: Amount: _____ Frequency: _____ Duration: _____ Type: _____

☐ Prescription drugs (abuse only): Amount: _____ Frequency: _____ Duration: _____ Type: _____

☐ Inhalants (abuse only): Amount: _____ Frequency: _____ Duration: _____ Type: _____

☐ Illegal drugs, type: _____ Method of Administration: _____

Other: _____

Please List Family and/or Household Members:

Name	Age	Relationship to client	Where living
			☐ At Home ☐ Out of the home
			☐ At Home ☐ Out of the home
			☐ At Home ☐ Out of the home
			☐ At Home ☐ Out of the home
			☐ At Home ☐ Out of the home
			☐ At Home ☐ Out of the home
			☐ At Home ☐ Out of the home
			☐ At Home ☐ Out of the home

If client is a child or adolescent and parents are divorced or separated, please describe current living arrangements/custody/parenting plan for children:

_____

_____

Emergency Contact Person: _____ Telephone # (_____)_____