ARCHWOOD
Counseling Services, LLC

Intake Form

New Client Information

Date: _____

First name: _____ Last name: _____ Date of birth: _____ Age: _____

Ethnicity: _____ ☐ Male ☐ Female Sexual orientation: _____

Do cultural or ethnic factors affect treatment? ☐ Yes ☐ No If yes, please explain: _____

_____

Do you have a religious affiliation? ☐ Yes ☐ No If yes, please explain: _____

Partner's name: _____ ☐ Unmarried ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed How long? _____

Educational level: _____ Occupation: _____ Employer: _____

If employed, how long at current job? _____ School (for child client): _____

Home address: _____ City: _____ State: _____ Zip: _____

Phone 1: _____ Phone 2: _____ Email: _____

Is it okay to contact you and leave a message on your: Phone 1 ☐ Yes ☐ No Phone 2 ☐ Yes ☐ No Email ☐ Yes ☐ No

Emergency contact (name): _____ Phone 1: _____

Home address: _____ City: _____ State: _____ Zip: _____

Who referred you for counseling? _____

Primary Billing Form

Please select the insured's relationship to the client: ☐ Self ☐ Spouse ☐ Partner/Other ☐ Child

If different from client, complete the following:

First name: _____ Last name: _____ Date of birth: _____ ☐ Male ☐ Female

Home address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Insurance plan: _____ ID#: _____ Group: _____

Employer/School: _____

Secondary Insurance

First name: _____ Last name: _____ Date of birth: _____ ☐ Male ☐ Female

Home address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Insurance plan: _____ ID#: _____ Group: _____

Employer/School: _____

Child Client

Current Parents/Guardians/Foster Parents with Primary Legal Custody

First name: _____ Last name: _____ Age: _____ ☐ Male ☐ Female

First name: _____ Last name: _____ Age: _____ ☐ Male ☐ Female ☐ Step Parent ☐ Deceased

☐ Parent(s) ☐ Adoptive Parent(s) ☐ Guardian(s) ☐ Foster Parent(s) How long? _____

☐ Unmarried ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed How long? _____

If deceased, please list cause of death and when: _____

Please explain living arrangement if child is not living with natural parents or if parents are separated or divorced including names, known whereabouts of each natural parent, their status of relationship with the child and existence of step parents:

_____

_____

Name of child's school: _____ Grade: _____

Is the child working with a Guidance Counselor? ☐ Yes ☐ No Counselor's name: _____

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Presenting Problem

Tell me what brings you here (include events that have prompted your call/current stressers/relevant history)?

What is your desired goal/outcome of treatment?

Family of Origin

Adult clients: Please list your own parents here. • Child clients: Please list grandparents.

First name: Last name: Age: Male Female Deceased

First name: Last name: Age: Male Female Deceased

Unmarried Partnered Married Separated Divorced Widowed How long?

If deceased, please list cause of death:

First name: Last name: Age: Male Female Deceased

First name: Last name: Age: Male Female Deceased

Unmarried Partnered Married Separated Divorced Widowed How long?

If deceased, please list cause of death:

Household

Adult clients: Please list all your children youngest to oldest here. • Child clients: Please list all siblings youngest to oldest.

Name	Sex	Date of birth	Age	Lives with	If from prior relationship, list partner
	Male Female Deceased				
	Male Female Deceased				
	Male Female Deceased				
	Male Female Deceased				

Other significant figures in the family or your life:

Please include information I should know about deaths of children:

Adult Client Family Constellation

Adult clients: Please list your brothers and sisters here.

Name	Sex	Age	State of mental and physical health	Deceased	Cause of death
	Male Female			Y N	
	Male Female			Y N	
	Male Female			Y N	
	Male Female			Y N	
	Male Female			Y N	

Please include any additional family members here or on the back of this form:

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Client's Medical History

Primary care physician name: _____ Date last seen: _____ Date of last physical: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone : _____ Fax: _____

List any hospitalizations (approximate dates) and outcomes from any physical illness: _____

List treatment received for any physical illnesses and current condition. (Serious accident, thyroid, diabetes, allergies, etc.):

List medications client is currently taking for physical illness, dose, when started and Doctor prescribing: _____

List medications client has taken in the past for physical illness: _____

Alcohol/Drug Use

List drug and alcohol use history including use of marijuana, amphetamine, cocaine, hallucinogens, barbiturates, opiods, abuse of prescription drugs, caffeine and tobacco.

List substance	C=Current P=Past use	Amount	Frequency	Duration	First use	Last use
	☐ C ☐ P					
	☐ C ☐ P					
	☐ C ☐ P					

Past Treatment: ☐ Inpatient treatment ☐ Outpatient treatment Number of attempts at sobriety: _____

12 Step Explain: _____

Occupational Concerns

☐ High stress ☐ Heavy lifting ☐ Hazardous materials List other occupational concerns here: _____

Behavioral Health History

Name of physician prescribing psychiatric medication if different from PCP: _____

Home address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ Date last seen: _____

List psychiatric hospitalizations (approximate dates) and outcomes: _____

List treatment received for any psychological or psychiatric concerns (Psychotherapy, Out-patient treatment or Group therapy):

List medications currently taken for mental or behavioral health: _____

List medications previously taken for behavioral health and doctor prescribing if different than above: _____

Please check if any blood relatives have any of the following:

	Which relatives?		Which relatives?
☐ Attention and learning problems		☐ Heart disease, Stroke	
☐ Alcohol/Drug problems		☐ High blood pressure	
☐ Asthma, Hay fever		☐ Psychiatric disorders	
☐ Cancer		☐ Sexual dysfunction	
☐ Diabetes		☐ Thyroid problems	

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Social History

Please briefly describe any complications in the following areas of the client's development:

Legal issues (arrests, convictions, probation, etc): _____

Problems with verbalizing anger: _____

History of breaking things in anger: _____

History of physically hurting people when angry: _____

Difficulty getting and keeping intimate relationships: _____

Other complications (e.g. Employment problems): _____

Please comment on any of the following events and briefly describe the client's reaction to:

Major illness: _____

Deaths: _____

Divorce: _____

Remarriages: _____

Frightening experiences: _____

Loss of friendships: _____

Other traumatic events: _____

Education/Work History:

Academic problems: _____

Learning disabilities: _____

General performance as a student: _____

General performance on the job: _____

Describe any recent change in your performance at school/work/home: _____

_____

Abuse

☐ Current ☐ Past Physical/sexual abuse, or child/elder neglect: ☐ Yes ☐ No

Has the abuse been legally reported? ☐ Yes ☐ No

Is there any current risk of further abuse by perpetrator? ☐ Yes ☐ No If "yes" to any of the above, please explain:

_____

Current Functioning

	Not Applicable	No Problems	Mild Problems	Moderate Problems	Serious Problems	Cannot Function
On the job						
In the marital/significant other relationship						
In relationships with own children						
In relationships with people outside your family						
In relationships with peers at school						
In relationships with adults at school						
In school work						