 R. March 2021 VWK

Date ________________

CLIENT INTAKE INFORMATION PACKET

The information in this packet is used by your clinician for administrative purposes, and more importantly, to become familiar with your presenting concerns, history, and possible areas of mental health and wellness to be worked on in your clinical counseling services. Please answer as thoroughly as you can, as if you are communicating with your counselor before your therapy actually begins. This packet information is stored with HIPAA compliant measures.

Client First/Last Name (s): ______________________________ **Age**:____________

Date of Birth: ____________

If primary client is a minor child, name(s) of **Parent/Guardian**: ______________________________

Address: ______________________ City______________ State ______ Zip ______

How would you describe your occupation/title/position? ______________________________

Phone: (Please check the boxes for methods of contact that are permitted.)

☐ Cell: ______________ ☐ Home: ______________ ☐ Work ______________

Email: ______________________________ (REQUIRED FOR SCHEDULING AND BILLING)

Please list all **members of your household:**

Name	Relationship	Male/Female, Transgender, Non-Conforming, Prefer not to say	Date of Birth/Age	Employer/Work or School

Adults:

1. ______________________________
2. ______________________________

Name	Relationship	Bio, Step, Foster, Adopted	Male/Female, Transgender, Non-Conforming, or Prefer not to say	Date of Birth/Age	Employer/Work or School

Children:

3. ______________________________
4. ______________________________
5. ______________________________
6. ______________________________
7. ______________________________
8. ______________________________
9. ______________________________
10. ______________________________

Other significant members of your "system" (in or out of household, e.g. adult children, seniors who live in the home, etc):

11. ______________________________
12. ______________________________

Our mission is for every human
we help to feel secure.

PLEASE COMPLETE PAGES 2-7 FOR EACH PERSON IN TREATMENT

(For example: If treating a couple, one set of background information for each partner; if treating a family, one set of information for each family member).

Name of Person (regarding answers in pages 2-7): ______________________________

Currently, I am: (Check one)

☐ MINOR CLIENT (<18 years old) ☐ Single Adult ☐ Coupled, but not married ☐ Married

Wedding date: ____________

Have you ever been **married before**? YES NO

If yes, please explain your **relationship history**:

☐ Divorced ☐ Separated ☐ Widowed

If applicable, separation/divorce **date**: ____________ If applicable, **date** of Partner's death: ____________

____

____

Partner's Address **if different** from yours: ______________________________

Phone: ____________________

Who may we contact in the event of an **emergency**?

Name: ____________________ Phone: ____________ Relationship: ____________

Presenting Concern

Please describe briefly the concern or situation, which led you to seek counseling services at this time:

____

____

____

How long has this been a concern? ____________

Have you experienced this type of concern **before** (circle one)? YES NO If so, when?________

Have you had any significant events – either positive or negative – occur recently or within a notable amount of time, such as job/school changes, death(s), changes in finances, living situation, illness, infertility, identity changes, etc?

____

Medical and Physical History

Medical Doctor's Name (general physician or other doctor you regularly visit):

____

Do you regularly have physical **wellness check-ups**? YES NOT REALLY

*NOTE: There will be a Waiver of Medical/Psychiatric Consultation in the consent forms in the back of the packet. Your clinician is NOT a medical doctor, and the Kansas Law KSA 65-6404(b)(3) requires mental health professionals consult with your physician to discuss or rule out medical conditions or medications that would explain your presenting symptoms. Because this Kansas law conflicts with federal HIPPA by requiring your clinician to contact someone outside of the therapy relationship, we have this form for you to *waive this contact requirement.* If you want your clinician to contact *anyone outside of the therapy relationship,* the separate Disclosure (Release of Information) Authorization Form (available online or from your counselor) will allow this consultation.

Have noticed any **recent changes in the following physical areas** (check all that apply):

- [ ] vision
- [ ] hearing
- [ ] coordination
- [ ] balance
- [ ] strength
- [ ] speech
- [ ] memory
- [ ] thinking
- [ ] energy
- [ ] sleeping
- [ ] eating
- [ ] menstruation
- [ ] sexual activity
- [ ] drinking fluids
- [ ] urination
- [ ] elimination
- [ ] other physical concerns

Have you (person whose background this regards, whether adult or child) experienced any of the following:

- [ ] Stressful prenatal experience prior to your own birth (biological mother's emotional stress, medical difficulties, etc)
- [ ] Difficult birthing (e.g. oxygen deprivation, abnormal presentation, prolonged labor, etc.)
- [ ] Prematurity/Newborn Intensive Care Unit (NICU)
- [ ] Early hospitalization in childhood/adolescence
- [ ] Domestic or international adoption and/or foster care

Please briefly explain circumstances of any above checked items.

____

____

Mental Health History

Are you currently seeing a **counselor, therapist, psychologist, or psychiatrist**? YES NO

If yes, who? ____

If there are **other types of professionals** you are currently consulting with, (e.g. school counselors, occupational therapists, nutritionists, chiropractors, acupuncturists, massage therapists, internal or integrative medicine, specialized medicine doctors) which types of professionals?

____

Have you ever had counseling **before**? YES NO If so, **when and why**?

____

____

Was the counseling experience **helpful**? YES NO **Why or why not?**

____

Have you ever had **medication prescribed historically** for psychiatric/emotional difficulties? YES NO If so, please **list**:

____

Are you **currently on any medications**? YES NO If so, please **list:**

____

Did/Do you find these medications **helpful**? ______________________ **Why or why not?**

____

Have you ever been physically, sexually, emotionally **abused**? YES NO

If yes, briefly **describe** (optional):

____

Have you ever been **hospitalized** for mental or emotional problems? YES NO

If yes, **when and where**? ____

____

Are you experiencing any issues related to **sexual behavior** (i.e. desire, performance, pornography use, infidelity, etc)?

YES NO

____

____

Are you experiencing any issues related to sexual or gender identity, questioning, difficulty with others understanding you, or other LGBTQIA+ issues)? YES NO

If yes, please explain: ____

____

How concerned are you about the impact of **racial** identity, racism, xenophobia, discrimination on you personally?

Not at all Not very much Somewhat Very Extremely

Please explain: ____

____

Our office is on the first floor of our building. We recognize all bodies are different and want to be supportive of all the bodies that come through our practice. Do you have any accessibility needs (wheelchair access, etc) or other things you'd like us to know?

____

Have you ever had thoughts of "not being here," hopelessness, or ideas of/**attempts** of suicide? YES NO

If yes, **how and when:** ____

____

Are you **suicidal now**? YES NO

How often do you drink **alcohol**? ____________________

Have you ever been arrested for **driving under the influence** (DUI)? YES NO

Do you smoke or use **tobacco**? YES NO

If yes, **how much?** ____________________

Do you use **cannibis,** medically or recreationally? YES NO

Do you use **other substances** (prescription medications, inhalants, cocaine, steroids, etc)? If yes, **what** do you use and **how often**? ____

Do you have any concerns about **alcohol or drug usage by members of your family**? YES NO

If yes, please **explain**: ____

Do you feel you or a family member have any problems with **spending/shopping or gambling**? YES NO

If yes, please **explain**: ____

Are you currently involved or do you expect to be involved in any **court related matters**? YES NO

If yes, please **describe** ____

____

*NOTE: Please familiarize yourself with the policies on Court-Related Matters in this packet if you anticipate your clinician will be asked to participate on behalf of your client system.

Have you currently or in the past **restricted food** consumption, **binged** on food, or **purged**/vomited/taken laxatives?

YES NO If yes, please **describe** ____

Have any other **biological relatives had relational or individual mental health concerns -** psychiatric or emotional difficulties (circle one)? YES NO

If so, which relatives and **what kind** of concerns?

____

____

Family of Origin Comments

Who was in your family growing up (include any changes to family situation/your age):

____

____

What information would you like us to know about your relationship(s) with your parents before we get started?

____

____

Anything else your clinician should know about your family of origin from the outset?

____

____

Support System

Who/what do you currently turn to when you need support?

____

____

Do you feel adequately supported in your life? YES NO

If not, what is lacking? ____

What activities do you feel nourished by? ____

What are your strengths in difficult times? ____

____

The Big Symptom Checklist

(Individuals: Check all that apply. Couples/Families: Please put initials of each person next to the problems that apply if you would like to note it about another person.)

- [ ] very unhappy, no joy
- [ ] withdrawn/isolation
- [ ] worry
- [ ] nervousness
- [ ] impatient, difficulty waiting
- [ ] talking excessively, pressured speech
- [ ] short attention span
- [ ] marital problems
- [ ] divorce
- [ ] separation
- [ ] school problems
- [ ] financial stress
- [ ] social problems
- [ ] feel rejected, abandoned
- [ ] trouble with the law
- [ ] push-pull behaviors with others
- [ ] health problems
- [ ] memory loss, forgetfulness
- [ ] terminal illness
- [ ] seizures
- [ ] impulsive
- [ ] mean to others
- [ ] hair pulling, nail biting
- [ ] property damage, breaking things
- [ ] self-mutilating, self-harm
- [ ] delusions
- [ ] stressed out
- [ ] can't make decisions
- [ ] lack initiative
- [ ] bed wetting
- [ ] feeling worthless or inferior
- [ ] depression
- [ ] homicidal thoughts
- [ ] verbal abuse
- [ ] irritable
- [ ] daydreaming
- [ ] overactive
- [ ] anger, resentment
- [ ] feel unheard, unseen
- [ ] interrupts, intrusiveness
- [ ] can't concentrate
- [ ] problems w/ ex-spouse
- [ ] work problems
- [ ] employment problems
- [ ] difficulty with organization
- [ ] problems with parents
- [ ] parenting problems
- [ ] problems with extended family
- [ ] death of a family/friend, grief
- [ ] infidelity, extra relationship
- [ ] eating problems
- [ ] stomach/bowel problems
- [ ] autoimmune issues, disease(s)
- [ ] lack of energy
- [ ] stubborn
- [ ] self-control problems
- [ ] fidgety, squirmy, restlessness
- [ ] violence with others
- [ ] repetitive/ritualistic behaviors
- [ ] hallucinations
- [ ] panic attacks
- [ ] shyness
- [ ] drug use
- [ ] nightmares
- [ ] loneliness
- [ ] insecurity
- [ ] suicidal thoughts
- [ ] sexual abuse
- [ ] temper outbursts
- [ ] fearful
- [ ] slow
- [ ] feelings of guilt
- [ ] feelings of shame
- [ ] silent treatment, icing out
- [ ] distractible
- [ ] relationship problems
- [ ] problems with friends
- [ ] career choices
- [ ] need for control
- [ ] problems with siblings
- [ ] problems with children
- [ ] history of trauma
- [ ] sexual problems
- [ ] problems with pornography
- [ ] sleeping problems
- [ ] chronic pain
- [ ] headaches
- [ ] tiredness, fatigue
- [ ] lying
- [ ] stealing
- [ ] oppositional
- [ ] strange behavior
- [ ] strange thoughts
- [ ] periods of feeling dissociated
- [ ] anxiety attacks
- [ ] undependable
- [ ] alcohol use
- [ ] crying spells
- [ ] frustration
- [ ] emptiness
- [ ] physical abuse
- [ ] emotional abuse

Demographic Information

How would you best **describe yourself** (check all that apply):

- ☐ African American/Black
- ☐ Asian
- ☐ European American/White
- ☐ Hispanic/Latino/Spanish origin
- ☐ Indigenous/Native American
- ☐ Native Hawaiian/Pacific Islander
- ☐ Middle Eastern, North African
- ☐ Not Listed or Most Specific ______________________________

Current **Employment Status**(es) of Household:

- ☐ Employed full time (40+ hrs)
- ☐ Employed part time (<39 hours)
- ☐ Unemployed and searching
- ☐ Student
- ☐ Retired
- ☐ Unemployed, not searching
- ☐ Homemaker
- ☐ Self-employed
- ☐ Unable to work

Household **Socioeconomic** Level (annual):

- ☐ Less than $25,000
- ☐ $25,000 - $49,999
- ☐ $50,000 - $99,999
- ☐ $100,000-$199,999
- ☐ $200,000+
- ☐ Prefer not to specify

Education of Adults in Household (put initials of each adult if more than one):

- ☐ Some High School
- ☐ High School Graduate
- ☐ Some College
- ☐ Associate's Degree
- ☐ Bachelor's Degree
- ☐ Master's Degree
- ☐ Doctorate
- ☐ Trade/Specialty

School/District(s) of children/teens, if applicable: ______________________________

Do you consider yourself **spiritual**? YES NO

Comments: ______________________________

If yes, do you currently express this spirituality through **religious practice** (Judaism, Christianity, Hinduism, Buddhism, etc)?

YES NO Comments: ______________________________

Would you like your **spirituality** included in your counseling? YES MAYBE NO

NOTE: Secure provides clinical counseling, and discussion of religion/spirituality are discussed only when initiated by you, if you desire that to be a part of your treatment.

After completing this packet and thinking through your presenting concerns, symptoms, and history, what are your **goals for treatment** (what do you want to **accomplish** with counseling)? **Is there anything else you feel is important for your therapist to know?** ______________________________

____

____

How did you **hear about** Secure Counseling Clinic or your counselor (check all that apply)?

- ☐ Internet search
- ☐ Psychology Today
- ☐ Secure Counseling website
- ☐ Social Media (Facebook, etc)
- ☐ A Professional
- ☐ Agency/Organization
- ☐ Religious leader, Group
- ☐ Individual/Friend/Family

If referred by a **specific person**, who? ______________________________

If applicable, do I have **permission to thank the person** who referred you? (circle one) YES NO

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we help to feel secure.