



9915 E. Bell Rd., Suite 120, Scottsdale, AZ 85260

**INTAKE INFORMATION**

Referred by: Self Doctor Friend Family member Other Date \_\_\_\_\_

Client Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cellular Phone \_\_\_\_\_ Email \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

Name of Primary Care Doctor (if applicable) \_\_\_\_\_ Phone \_\_\_\_\_

Name of Psychiatrist (if applicable) \_\_\_\_\_ Phone \_\_\_\_\_

**Other Client Demographic Information:**

Ethnicity \_\_\_\_\_ Marital Status S / M / DP / D / W Number of Marriages \_\_\_\_\_

If Married or Divorced, for how long? \_\_\_\_\_ Occupation \_\_\_\_\_

Do you have any children? \_\_\_\_\_ What are their ages? \_\_\_\_\_

**Name(s) and relationship(s) of anyone accompanying you today:**

\_\_\_\_\_  
\_\_\_\_\_

**AREAS OF CONCERN—please check all that apply.**

<input type="checkbox"/> Feelings about yourself	<input type="checkbox"/> Work	<input type="checkbox"/> Grief/Loss	<input type="checkbox"/> Poor Sleeping	<input type="checkbox"/> Thoughts of Suicide
<input type="checkbox"/> Marital/Partner Issues	<input type="checkbox"/> Social Relationships	<input type="checkbox"/> Depression or Sadness	<input type="checkbox"/> Anger or Irritability	<input type="checkbox"/> Other
<input type="checkbox"/> Family Relationships	<input type="checkbox"/> Life Transitions	<input type="checkbox"/> Anxiety/Panic	<input type="checkbox"/> Sexual Problems	
<input type="checkbox"/> Parenting Issues	<input type="checkbox"/> Traumatic event(s)	<input type="checkbox"/> Poor Concentration	<input type="checkbox"/> Alcohol/Drugs	

**What difficulties are you currently experiencing?**

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**How long have these difficulties been a concern?**

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**How do these difficulties affect you and/or your family?**

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**Are you receiving help for these difficulties anywhere else? Where? Is it helpful?**

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**What do you hope to accomplish by participating in counseling? How will you know if you are making progress?**

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**Have you or anyone in your family received counseling in the past? When? Was it for related or different difficulties? Was it helpful?**

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**Is there anyone not present today that you would like included in future counseling sessions?**

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**If you live with other people, what are the names and ages of the people you live with? What is their relationship to you? Are you dissatisfied with any aspects of your home/living environment?**

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**Please list any medications you are currently taking.**

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**Please list any past psychiatric medications that you have taken. Did the medication help?**

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**Have you ever been hospitalized for psychiatric treatment? If so, when and where were you hospitalized?**

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**Do you have any medical conditions or health problems? If so, are you receiving treatment?**

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**Please list any immediate or extended family members who have suffered with mental illness or substance abuse.**

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**Have you ever attempted suicide? If yes, please provide details.**

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**Do you currently drink alcohol? Approximately how many drinks per week? Stop Date (if applicable)?**

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**Do you currently use recreational drugs? What types? How often? Stop Date (if applicable)?**

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**Have you ever been concerned about your use of alcohol or drugs?**

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**Has someone else ever expressed concern about your alcohol or drug use?**

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**Are you currently involved in any civil or criminal legal proceedings?**

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**Have you been involved in any criminal legal proceedings in the past?**

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**Who are your primary supports in life? Please include both formal (e.g., groups) and informal (e.g., friends, family).**

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**Is there any information you would like to provide regarding your culture, your spiritual/religious beliefs and practices or any other significant aspects of your life?**

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