



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 _____ Cell Phone _____ Email _____

Okay to Leave a message on Home Cell

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 currently married, how long? _____ If Divorced, what date(s) did divorce(s) finalize? _____

Do you have any children? _____ What are their ages? _____

Occupation _____

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

AREAS OF CONCERN—please check all that apply.

| Feelings about yourself | Work | Grief/Loss | Poor Sleeping | Stress |
|------------------------------|----------------------------|-----------------------------|--------------------------|---------------------------|
| _____ Marital/Partner Issues | _____ Social Relationships | _____ Depression or Sadness | _____ Poor Concentration | _____ Finances |
| _____ Family Relationships | _____ Age/Stage of Life | _____ Anxiety/Panic | _____ Sexual Problems | _____ Health Issues |
| _____ Parenting Issues | _____ Traumatic event(s) | _____ Anger or Irritability | _____ Alcohol/Drugs | _____ Thoughts of Suicide |

What is the biggest difficulty or difficulties are you currently experiencing?

How long have these difficulties been a concern?

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

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

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

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

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

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?

Please list any medications you are currently taking.

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

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

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

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

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

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

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

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

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

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

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

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

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?
