ERJ COUNSELING

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Child, Adolescent, Family & Couples Therapy

Intake Form

Date: _____

How were you referred to our office? _____

Client's Full Name: _____

Age: _____ **Sex:** _____ **Date of Birth:** _____ **SS#:** _____

Marital Status: _____ **Married** _____ **Divorced** _____ **Single** _____ **Widow/Widower**

Client's Primary Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Client's Home Phone: _____ **Mobile Phone:** _____ **Work Phone:** _____

Email Address: _____

Employer or School/Grade: _____

Is Client a minor, under 18? _____ **Yes** _____ **No**

If yes, please list your name: _____ **Relationship to client:** _____

Contact Numbers: Home: _____ **Mobile:** _____ **Work:** _____

Email Address: _____

Marital Status _____ **Married** _____ **Divorced** _____ **Single** _____ **Widow/Widower**

Are you the sole parent/guardian? _____ **Yes** _____ **No** **SS#:** _____

If no, please list other legal guardians:

Name _____ **Relationship:** _____

Contact Numbers: Home: _____ **Mobile:** _____ **Work:** _____

Street Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Name: _____ **Relationship:** _____

Contact Numbers: Home: _____ **Mobile:** _____ **Work:** _____

Street Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Presenting Problem: _____

_____

_____

_____

_____

_____

_____

Client's Name: _____

Primary Care Physician: _____ **Contact Number:** _____

Date of Last Full Physical Exam: _____

Is client experiencing depressive symptoms? _____ **Yes** _____ **No**

If yes, has client had a blood test to check their thyroid levels? _____ **Yes** _____ **No**

Has client talked about wanting to hurt self or others? _____ **Yes** _____ **No**
If yes, please explain:

_____

_____

_____

Is client taking psychotropic medications: _____ **Yes** _____ **No**
If yes, please list type and quantity:

_____

_____

_____

_____

Previous Counseling: **Dates:**

_____

_____

_____

_____

List Current Alcohol / Drug Use:

_____

_____

_____

Other Relevant Medical or Psychiatric History (Please include history of mental illness in family):

_____

_____

_____

_____

Name of Emergency Contact: _____

Contact Numbers: **Home:** _____ **Mobile:** _____ **Work:** _____

Street Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Family Information: List People Currently Living in Your Household			
Name:	**Relationship:**	**Age:**	**Occupation/ Grade Level**

 Client's Name: _____

Please check any current symptoms or symptoms experienced during the past few weeks:

( ) Anger Outbursts
( ) Chronic sadness
( ) Crying episodes
( ) Hopelessness
( ) Difficulty concentrating
( ) Loss of appetite
( ) Overeating
( ) Nausea/Vomiting
( ) Current or past eating disorder
( ) Difficulty making decisions
( ) Low energy/fatigue
( ) Agitation
( ) Restlessness
( ) Excessive worry
( ) Fearfulness
( ) Feeling bad about self
( ) Trembling/shaking
( ) Fear of loss of control
( ) Fear of dying
( ) Intrusive thoughts of bad memories
( ) Flashbacks/re-living bad experiences
( ) Hear voices others do not hear
( ) Fearful others are talking about me
( ) Difficulty completing tasks/distracted
( ) Difficulty focusing
( ) Tendency to act impulsively
( ) Physically aggressive toward animals
( ) Problems with alcohol/drugs (now or past)
( ) Not well organized
( ) Legal Problems
( ) Difficulty meeting goals/deadlines
( ) Racing thoughts
( ) Excessive spending
( ) Excessive gambling
( ) Aggressive/abusive toward others
( ) Aggressive towards objects
( ) Compulsive rituals
( ) Hoarding
( ) Thoughts of hurting self
( ) Past suicide attempt
( ) Behavioral Problems at home and/or school
( ) Low frustration tolerance
( ) Irritability
( ) Sleep problems
( ) Memory problems
( ) Thoughts of suicide
( ) Withdrawing from others
( ) Difficulty functioning at school or work
( ) Overwhelmed by upset/angry emotions
( ) Difficulty functioning socially
( ) Reduced interest/pleasure in activities
( ) Panic attacks
( ) Fear of leaving home
( ) Avoidance of public places
( ) Avoidance of social situations
( ) Feeling angry often
( ) Pounding heart/palpitations
( ) Shortness of breath
( ) Feeling detached from others/life
( ) Nightmares
( ) Easily startled/upset
( ) Seeing things others do not see
( ) Fearful someone is plotting against me
( ) Taking on too many tasks
( ) Frequent forgetfulness
( ) Difficult to wait my turn
( ) Feelings of superiority
( ) History of pregnancy
( ) Problems with peers/ co-workers
( ) Problems in school (now or in past)
( ) Hard to stay with a job/activities very long
( ) Staying up for days without sleep
( ) Multiple sexual partners
( ) Relationship Problems/Marital conflict
( ) Confused/worried about sexual behavior
( ) Provocative dress
( ) Obsessive thoughts
( ) Hair pulling
( ) Breaks house, school or other rules/laws
( ) Thoughts of physically hurting others

Please describe any other symptoms the client is having at this time: _____
_____
_____
_____
_____

Please email all forms back to beth@erjcounseling.com. Thank you