Lafayette Psychology Center
Client Intake Form

Name: _____

Preferred Name: _____

If client is a minor, parents'/guardians' names and relation:

_____
_____

Date of Birth: _____

Gender Identity: _____

Age: _____ Race: _____

Ethnicity: _____

Address: _____
_____
_____

Phone: (home)_____
(work)_____
(cell)_____

Email:
_____
Appointment reminders are sent via email.

Is it ok to leave a message? _____

Would you like to receive appointment reminders?

☐ Yes ☐ No

Preferred phone number for contact:

☐ Home ☐ Work ☐ Cell

Relationship Status:

- ☐ Single, never married
- ☐ Married
- ☐ Living with partner
- ☐ In a relationship
- ☐ Divorced
- ☐ Widowed
- ☐ Other: _____

Affectional Orientation:

- ☐ Straight/Heterosexual
- ☐ Lesbian
- ☐ Gay
- ☐ Bisexual
- ☐ Asexual
- ☐ Other: _____

<u>Emergency Contact</u>

Name: _____

Relationship: _____

Phone: _____

Alternate Phone: _____

** During certain situations, it may become necessary for this office to contact your emergency contact. These instances will be discussed during your first session. **

If someone other than the client is completing this form, please complete this section before continuing to the rest of the form.

_____
Printed Name

_____
Relationship to Client

_____
Signature

_____
Reason for Your Assistance

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We at Lafayette Psychology Center understand the sensitive and private nature of the questions included in this form. Please understand that your record is confidential subject to a few exceptions. Some of those exceptions include, but are not limited to, reports of child abuse, reports of abuse of vulnerable adults, reports of high risk to harm yourself or others, involvement in personal injury litigation, child custody litigation, or when subpoenaed by the court system due to your involvement in criminal activity with a claim of insanity as a defense.

If you have any further questions, please feel free to discuss them with your therapist.

I attest, by my signature below, that I have read and understand the above statement.

_____ _____
Signature Date

Description of Concern

1. What caused you to seek counseling at this time? What is your main concern? (please be specific)

_____
_____
_____
_____
_____
_____
_____

2. How long has this concern persisted?

☐ Several Days ☐ Past Year
☐ Several Weeks ☐ Past Two Years
☐ Several Months ☐ Several Years
☐ There is no concern

3. How did these concerns begin?

☐ Suddenly ☐ Over months
☐ Over days ☐ Over years
☐ Over weeks ☐ There is no concern

4. Has this concern ever been better or worse?

☐ Yes, better ☐ Yes, worse
☐ No, always the same ☐ Never had it before
☐ There is no concern

5. Have you been treated for this concern before?

☐ No ☐ Yes, with success
☐ Yes, partial success ☐ Yes, no success
☐ There is no concern

6. If yes, who was your mental health provider?

_____

7. What was your diagnosis?

_____

8. What medications, if any, were you prescribed for this concern?

_____
_____
_____
_____

9. Are you still taking these medications?

☐ Yes ☐ No ☐ Does not apply

10. If yes, do you feel that they are working?

☐ Yes ☐ No

11. If no, why did you stop?

☐ Prescription ran out
☐ Doctor's orders
☐ I did not like the way it made me feel
☐ Side effects

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Background Information

12. Is English your native Language?

☐ Yes ☐ No

13. If not, what is your native language?

_____

14. Do you feel that you are fluent enough in English to intelligently participate in assessments and/or treatment?

☐ Yes ☐ No

15. To the best of your knowledge, how would you describe the time frame in which you achieved early developmental milestones such as walking and talking?

☐ Do not know

☐ At the normal age

☐ Earlier than most children

☐ Later than most children

16. Did religion play a role in your upbringing?

☐ Yes ☐ No

17. If yes, which faith tradition/religion impact your childhood? (List all that may apply)

_____
_____
_____
_____

18. Which faith tradition/religion impact your current life? (List all that may apply)

_____
_____
_____
_____

19. Which choice(s) best describe your current relationship status?

☐ No relationship ☐ Online

☐ Happily married ☐ Unhappily married

☐ Seriously dating ☐ Casually dating

☐ "One night stands" ☐ Dating services

☐ Online dating service ☐ Singles groups

☐ Sex Clubs ☐ Successful flirting

☐ Happily living with partner

☐ Unhappily living with partner

☐ Other: _____

20. If you are currently in a relationship, how long have you been in your relationship?

_____

21. How many children do you have with your current spouse/partner?

_____

22. Do you have any children from a previous relationship?

☐ Yes ☐ No

23. If yes, how many? _____

Medical & Mental Health History

24. Have you seen a mental health professional before?

☐ Yes ☐ No

25. If yes, please describe (including year, place, length of treatment, issues experienced, diagnosis, type of treatment):

_____
_____
_____
_____
_____

26. Please list all medications/supplements you are currently taking and the reason you are taking them:

_____
_____
_____
_____

27. If you are currently taking prescription medication, please list the prescribing MD by name, type of MD, and phone number.

_____
_____
_____
_____

28. Who is your primary care physician?

Name: _____
Type of MD: _____
Phone: _____

29. Have you ever been hospitalized for a psychiatric issue?

☐ Yes ☐ No

30. If yes, please describe to the best of your recollection (including year, place, reason, length of hospitalization, diagnoses, type of treatment):

_____
_____
_____
_____

31. To the best of your ability, list all major injuries that you have experienced (motor vehicle injuries, work-related injuries, serious falls, fractures, etc.):

_____
_____
_____
_____

32. To the best of your ability, list every surgery (with dates) you have ever had:

_____
_____
_____
_____

33. To the best of your ability, list all major medical illnesses you have experienced and the year of diagnosis:

_____
_____
_____

34. Is there a history of mental illness in your family?

☐ Yes ☐ No

35. If yes, Please describe to the best of your knowledge (include relationship and diagnoses):

_____
_____
_____
_____

36. Do you have a history of trauma in any of the following areas:

☐ Childhood sexual trauma ☐ Childhood violence

☐ Family death or illness ☐ Adult sexual trauma

☐ Adult violence ☐ Personal major illness/injury

☐ Other: _____

37. What drugs (if any) have you ever used, and to what extent?

_____
_____
_____
_____

38. Do you have suicidal thoughts?

☐ Yes ☐ No

39. Date of most recent suicidal thoughts:

_____

40. Have you ever attempted suicide?

☐ Yes ☐ No

41. Date of most recent suicide attempts:

_____

42. Do you have thoughts/urges to harm others?

☐ Yes ☐ No

43. Date of most recent thoughts/urges to harm others:

_____

44. Please check any of the following you have experienced in the past six months:

☐ Increased appetite ☐ Decreased appetite
☐ Trouble concentrating ☐ Difficulty sleeping
☐ Excessive sleeping ☐ Low motivation
☐ Isolation from others ☐ Fatigue/low energy
☐ Low self-esteem ☐ Depressed mood
☐ Tearful/crying spells ☐ Anxiety
☐ Fear ☐ Hopelessness
☐ Panic
☐ Other: _____

Educational & Occupational History

45. Highest degree/diploma obtained:

☐ No diploma/degree ☐ Associates degree
☐ G.E.D. ☐ Bachelor's degree
☐ HS completion cert. ☐ Master's degree
☐ High school diploma ☐ Doctoral degree
☐ Tech. school cert. ☐ Other: _____

46. Did you skip any grades?

☐ Yes ☐ No

47. Did you repeat any grades?

☐ Yes ☐ No

48. Did you fail any grades? How Many?

_____

☐ Yes ☐ No

49. Did you have trouble with reading?

☐ Yes ☐ No

50. Did you have trouble with math?

☐ Yes ☐ No

51. Did you have trouble with your behavior?

☐ Yes ☐ No

52. Were you ever suspended? How many times? ____

☐ Yes ☐ No

53. Were you ever expelled? Why?

_____

☐ Yes ☐ No

54. Were you ever diagnosed with a learning disability? What was the official diagnosis?

_____

☐ Yes ☐ No

55. Were you ever fired from a job? How many times? _____

☐ Yes ☐ No

56. If you answered yes to the previous question, why were you fired?

_____
_____
_____
_____

57. Are you currently employed?

☐ Yes ☐ No

58. Current job title:

_____

59. Length of time in current position:

_____

60. Are you satisfied with your present job?

☐ Yes ☐ No

61. Do you currently have any legal issues or concerns?

☐ Yes ☐ No

62. If yes, please describe:

_____
_____
_____

63. What are your goals for counseling?

_____
_____
_____

64. What else would you like me to know?

_____
_____
_____

Additional Background for Minors

** Please continue with this section ONLY if the client is a minor **

65. Was the child adopted?

☐ Yes ☐ No

66. If so, at what age? _____

67. Please provide any information you may have about the child's biological parents:

_____
_____
_____
_____

68. Describe any problems with feeding, illnesses, sleep patterns, temperament, etc. during the child's infant and toddler periods:

_____
_____
_____
_____

69. Describe the personality, strengths, weaknesses, fears, relationships with peers and siblings, and general health concerns during the child's preschool years:

_____
_____
_____
_____

70. Describe your child's transition from home to preschool:

_____
_____
_____
_____

71. Describe any major changes, crises, etc. the family experienced during the child's preschool years:

_____
_____
_____
_____

72. List any special classes or services your child is receiving currently in school:

_____
_____
_____
_____

73. Describe any current or past academic problems:

_____
_____
_____
_____

74. Describe any current or past school related behavioral problems:

_____
_____
_____
_____

75. List any problems with teachers, homework, peers, or any other school related problems:

_____
_____
_____
_____

76. Please check all of the behaviors listed below that you believe your child currently exhibits to an excessive or exaggerated degree when compared to other children his/her own age. If there were but no longer are a concern please put a (P) for past concerns:

- ☐ High activity level
- ☐ Argumentative
- ☐ Withdrawn
- ☐ Demands attention
- ☐ Very tense
- ☐ Nightmares
- ☐ Outbursts/Tantrums
- ☐ Frequent interruptions
- ☐ Worrisome
- ☐ Doesn't listen to others
- ☐ Destructive
- ☐ Running away
- ☐ Frequent physical complaints
- ☐ Cries easily
- ☐ Poor attention span
- ☐ Very competitive
- ☐ Impulsive
- ☐ Easily frustrated
- ☐ Overly shy
- ☐ Under/Over eating
- ☐ Excessive fantasizing
- ☐ Stealing
- ☐ Aggressive
- ☐ Overly dependent
- ☐ Sexually acting out

77. List any major changes at home since beginning school (including moves, illnesses, job changes, separations/divorce):

_____
_____
_____
_____

78. Does your child seek friendship with other children?

☐ Yes ☐ No

79. Does your child make friends easily?

☐ Yes ☐ No

80. Do other children seek your child out for friendship?

☐ Yes ☐ No

81. Does your child associate primarily with others:

☐ His/Her Own Age

☐ Younger

☐ Older

82. How does your child spend time alone?

_____
_____
_____
_____

83. What are your child's main interests/activities?

_____
_____
_____
_____

84. What does your child enjoy doing the most?

_____
_____
_____
_____

85. What does your child dislike doing the most?

_____
_____
_____
_____

86. List any special skills, talents, or accomplishments:

_____
_____
_____
_____

87. What do you see as your child's greatest strengths?
_____
_____
_____
_____

88. Describe any current or past school, behavior, or medical problems of any of your child's brothers or sisters:
_____
_____
_____
_____

	Name	Date of birth/death	Current Location	Grade level/Occupation
Mother				
Father				
Siblings				
Step Mother				
Step Father				
Step Siblings				

89. Please list any other family members (grandparents, aunts, uncles, etc.) to whom your child is or was especially close to:
_____
_____
_____

90. Mother's history:
Education level (highest grade completed): _____
Number of siblings: _____
Briefly describe present relationship with her parents:
_____
Please describe any history of alcoholism, drug addiction, or emotional problems in mother's family: _____
_____

91. Father's history:
Education level (highest grade completed): _____
Number of siblings: _____
Briefly describe present relationship with his parents:
_____
Please describe any history of alcoholism, drug addiction, or emotional problems in father's family: _____
_____

92. Briefly describe any significant household moves, career decisions, marital changes, deaths, prolonged absences, etc. and the impact on the family.

93. Briefly describe any current or past school, behavior, or medical problems of any of your child's brothers or sisters.

Please use this section for any additional information or to continue answers requiring additional space. If you are using this section to answer a question from the form, please specify the question beside your response.