The Creative Social Worker, with Tiffany McCabe
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CLIENT INTAKE FORM

DEMOGRAPHIC INFORMATION

First Name:

Last Name:

Date of Birth:

Name you would like to be called *(if different from first name):*

Place of Birth:

Primary Language:

Relationship Status: ☐ single ☐ in partnership ☐ married ☐ divorced ☐ widowed ☐ other

If in partnership, partner's name & date of birth:

Child/children's name(s) and date(s) of birth:

Other significant dates: (e.g. wedding anniversary, sobriety anniversary, etc.)

HOME ADDRESS

Street:

City:

State/Province:

Zip/Postal Code:

MAILING ADDRESS (if different than home address)

Street:

City:

State/Province:

Zip/Postal Code:

PERSONAL CONTACT INFO

Home: May I leave a message? ☐ Yes ☐ No

Mobile: May I leave a message? ☐ Yes ☐ No

Work: May I leave a message? ☐ Yes ☐ No

E-mail Address (personal):

IN CASE OF EMERGENCY

Contact Name: Home:

Relationship to you: Mobile:

E-mail address:

Does your Emergency Contact know that I am your therapist? ☐ Yes ☐ No

WORK INFORMATION

Occupation:

Employer's name:

Place of work/Business name:

Work telephone:

Work email:

CLIENT QUESTIONNAIRE

1. Please describe in your own words the primary issue (s) for which you are seeking therapy:

____

____

____

2. How long has the current issue existed? When did it occur?

____

____

____

3. How frequently does it occur?

__Rarely __Occasionally __Weekly __Daily __Most of the time __Continuously

4. Please describe your expectations of counseling.
(In other words, how will things be different when counseling is successfully completed?)

____

____

____

5. Please check which BEHAVIORS recently apply to you:

☐ Frequent Crying ☐ Drink too much ☐ Sleep Problems ☐ Other: ____________
☐ Hyperactive Behavior ☐ Withdrawing ☐ Irresponsibility ☐ Other: ____________
☐ Lack of Assertiveness ☐ Arguing/ Irritability ☐ Self Neglect ☐ Other: ____________
☐ Lack of Energy ☐ Drug use ☐ Indecisiveness
☐ Temper Outbursts ☐ Eating Problems ☐ Working too much

6. Please check which FEELINGS recently apply to you:

☐ Restless ☐ Fearful ☐ Depressed ☐ Sad ☐ Annoyed
☐ Guilty ☐ Bored ☐ Unhappy ☐ Irritable ☐ Jealous
☐ Energetic ☐ Unreal ☐ Unattractive ☐ Relaxed ☐ Unmotivated
☐ Content ☐ Panicky ☐ Worthless ☐ Empty ☐ Other: ____________
☐ Confused ☐ Lonely ☐ Hopeful ☐ Happy ☐ Other: ____________
☐ Moody ☐ Stressed ☐ Angry ☐ Ashamed ☐ Other: ____________
☐ Mistrustful ☐ Like a failure ☐ Optimistic ☐ Excited
☐ Nervous ☐ Helpless ☐ Inferior ☐ Hopeless

7. Please check which PHYSICAL symptoms recently apply to you:

☐ Headaches	☐ Back Pain	☐ Chest Pains	☐ Loss of Sex Drive
☐ Dizziness	☐ Tiredness	☐ Fainting Spells	☐ Excessive Sweating
☐ Twitches/ spasms	☐ Memory Problems	☐ Black Outs	☐ Appetite Change
☐ Stomachaches	☐ Dry Mouth	☐ Overly Tense	☐ Other: ____________
☐ Racing Thoughts	☐ Tremors/ shakiness	☐ Cannot Concentrate	☐ Other: ____________
☐ Numbness/ tingling	☐ Rapid Heartbeat	☐ Dizziness	☐ Other: ____________

8. What are your major strengths, or what do you like about yourself?

____

____

____

9. What major transitions have you had in the past two years? (i.e. – entering or approaching a new decade of life, a new relationship, a new job, a new role, a new residence, changes in children's ages/stages of life, separation, divorce, death of a loved one, birth of a child, marriage, etc.)

____

____

____

10. Who are the key people in your life and what do they provide for you?

____

____

____

11. a) On a scale of 1 – 10, 10 = HIGH, rate your current level of stress: __________

b) What would you like it to be? __________

12. What are your primary stressors?

____

____

13. a) On a scale of 1 – 10, 10 = HIGH, rate the quality of your life today: ______

b) What would you like it to be? _______

PHYSICAL & MENTAL HEALTH

1. Do you currently have a primary physician? ☐ Yes ☐ No
Physician's Name: Telephone Number:

2. Are you currently being seen by a psychiatrist? ☐ Yes ☐ No
Psychiatrist's Name: Telephone Number:

3. Are you currently being seen by another counselor/therapist? ☐ Yes ☐ No
Counselor's Name: Telephone Number:

4. Rate your current level of health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Very Poor

5. Are there any serious health problems/disabilities/accidents (current, recent, or past) that I should know about or discuss? ☐ Yes ☐ No

6. What medications are you CURRENTLY prescribed for your physical and mental health?

Medications	Taken for	Date Begun	Dosage Frequency	Take as Prescribed? (Y/N)	Prescribing Physician
____________	____________	_________	____________	____________	____________
____________	____________	_________	____________	____________	____________
____________	____________	_________	____________	____________	____________
____________	____________	_________	____________	____________	____________

7. Please list any medication you were prescribed in the PAST.

Medications	Taken for	Date Begun	Dosage Frequency	Take as Prescribed? (Y/N)	Prescribing Physician
____________	____________	_________	____________	____________	____________
____________	____________	_________	____________	____________	____________
____________	____________	_________	____________	____________	____________
____________	____________	_________	____________	____________	____________

8. Have you received counseling in the past? ☐ Yes ☐ No If yes, complete the following:

What type of counseling?
☐ Individual ☐ Marital ☐ Family ☐ Alcohol abuse ☐ Substance Abuse ☐ Other _____________

When: ☐ Inpatient ☐ Outpatient
Was it helpful? ☐ Yes ☐ No
If no, explain: ____

Name of Provider/Facility: Issue Addressed:

Other?
☐ Individual ☐ Marital ☐ Family ☐ Alcohol abuse ☐ Substance Abuse ☐ Other _____________
When: ☐ Inpatient ☐ Outpatient
Was it helpful? ☐ Yes ☐ No
If no, explain: ____

Name of Provider/Facility: Issue Addressed:

SAFETY RISK INFORMATION

1. Have you or any close family members ever been suicidal or experienced a mental illness?
   ☐ Yes ☐ No
2. Have you had any recent thoughts about harming or killing yourself? ☐ Yes ☐ No
3. Have you ever attempted suicide? ☐ Yes ☐ No If yes, when? ___________
4. Have you had any recent thoughts about, or have recently harmed anyone else? ☐ Yes ☐ No

FAMILY OF ORIGIN/DEVELOPMENTAL INFORMATION

1. Who primarily raised you?

2. Who raised you in your first three years of life?

3. Did your parents experience separation/divorce?
   ☐ Yes ☐ No If yes, how old were you? _________

4. How many brothers and sisters do you have?	Brothers:	Step-brothers:	Half-brothers:
	Sisters:	Step-sisters:	Half-sisters:

5. What was your order in birth?
   ☐ Only child ☐ Youngest ☐ Middle ☐ Oldest

SOCIAL SUPPORT / SELF-CARE INFORMATION

1. How would you describe your current social interaction/support?

2. How did you meet your friends?

3. What activities do you enjoy?
Alone: With friends/family:

4. How often do you exercise?

5. What type of exercise, if any, do you enjoy or engage in?

6. How would you describe your eating habits?

7. Do you feel that you need to lose or gain weight? ☐ Yes ☐ No