Individual Client Intake Form
(please complete all pages)

BACKGROUND INFORMATION

Client Name: _____

Date of Birth (month/day/year): _____

Client Age: _____ Client Sex: _____ Client Ethnicity: _____

Address: _____ City: _____ State: ____ Zip: _____

Employer: _____ Occupation: _____

Email: _____ Home Phone: _____

Cell Phone: _____ Work Phone (optional): _____

Emergency Contact Person: _____ Relationship: _____

Emergency Contact Phone: _____

Referred by: _____

Primary Care Physician: _____

Have you had a physical from a medical provider in the previous two years? Yes No

Are you currently or have you ever received counseling? Yes No

If yes, please state when and with whom? _____

Presently Living with:		**Marital Status:**		**Highest Education Completed:**	
Parents	_____	Single	_____	Elementary School	_____
Spouse	_____	Married	_____	High School	_____
Roommate	_____	Separated	_____	College	_____
Alone	_____	Divorced	_____	Graduate School	_____
Other _____		Widowed	_____	Professional School	_____
		Other _____		Other _____	

If married, years of marriage: _____ Age when married: Husband: _____ Wife: _____

FAMILY MEMBERS

Relation	Name	Age	Occupation or Grade Level	√ if living with you
Mother:				
Father:				
Sibling:				
Sibling:				
Sibling:				
Child:				
Child:				
Child:				
Child:				
Other:				

Have there been any significant family events in the last year (i.e. death, serious illness, divorce, marriage, job change, domestic abuse, traumatic events, etc.)?

_____
_____
_____
_____

HEALTH INFORMATION

Rate your health: Very Good ___ Good ___ Average ___ Declining ___

Recent weight change: Lost _____ Gained _____

List all present and past illnesses, injuries, or handicaps that have required medication or physical care (Please place a check next to any that you are currently experiencing):

_____
_____
_____

Medication(s) currently using:

_____
_____
_____

Medication(s) allergies_____

Food allergies_____

RELIGIOUS BACKGROUND (Optional)

Religious preference: _____

Religious Place of Attendance: _____ Active Member: Yes No

Does your spouse and/or family share the same or similar religious preference? Yes No

Any religious/spiritual concerns? Yes No

Explain any recent changes or challenges in your spiritual life:

_____
_____
_____
_____

OTHER INFORMATION

Do you have insurance? Yes No

Name of insurance company? _____

Insurance ID _____ Group ID _____

Have you ever used drugs for anything other than medical purposes? Yes No

If married, has your spouse? Yes No

Have you ever used recreation drugs? Yes No Type (if yes): _____

Do you currently use recreation drugs? Yes No How often (if yes): _____

Do you drink alcohol? Yes No How many? ____ How often? _____

Do you have trouble sleeping? Yes No

How many hours of sleep do you average each night? _____

Circle any of the words that best describe you now:

persistent nervous impatient impulsive cautious moody sad depressed excitable shy introvert extrovert quiet loud lonely submissive self-conscious sensitive

other(s) _____

Please circle all that apply (any symptoms that you have experienced in the last 30 days):

Headaches - Nightmares - Self-injurious Behavior - Thoughts of Suicide

Stomachaches - Can't Trust Anyone - Strange Thoughts - Hopelessness

Feeling Worthless - Feel Like Crying - Panicky Feelings - Nervous

Poor Concentration - Ready to Explode - Memory Problems - Flashbacks

Hearing Voices - Seeing Things - Feeling Out of Control - Always Worried

Startled Easily - Appetite Problems - Loss of Interest (i.e. hobbies, sex, etc.)

Why am I so different? - People are Watching Me - Anger/Temper

Obsessiveness - Stress - Excessive Fear - Unexplained Aches/Pains

Compulsions - Problems Sleeping - Under-eating/Overeating

Any change in daily living skills (work, school, daily activities)? _____

Other (Please Explain) _____

Please briefly describe the main problem(s) which prompted you to seek counseling.

_____

_____

_____

Is there anything else which you believe might be important for your counselor to know?

_____

_____

_____

What do you hope will change as a result of coming to counseling?

_____

_____

_____

Please note that by signing below you are recognizing that the above information is as accurate and current as possible. You have received a copy of your rights, and consent to treatment by Higher Ground Life Services, Inc.

Signature: _____ Date: _____

CANCELLATION POLICY

At least 24-hour notice is required for session cancellation. The first failure to provide 24-hour cancellation notice will result in a $20.00 charge. Each subsequent failure to provide 24-hour cancellation notice will result in a $40.00 charge.

Please note, you are responsible for late cancellation fees, insurance companies do not normally cover them. If you're more than 10 minutes late, your session may have to be re-scheduled and you will be charged according to the $20.00 or $40.00 policy for late cancellations. If the session doesn't have to be re-scheduled, it will end at the originally scheduled time and you will be charged the full fee.

Our goal is to help people heal.
Your faithfulness in keeping appointments allows us
to better assist you.