ENVISION
INTEGRATIVE THERAPIES

**CLIENT INTAKE**
**Confidential**

Thank you for taking the time to complete this form.
Please include information that you believe is relevant to our working together.

Client Name: _____

Emergency Contact: _____ Relationship:_____

Contact Phone:_____

How did you hear my services or referral source?_____Phone _____

May I have your permission to contact this person to acknowledge the referral? ☐ yes ☐ no

(If you need additional space, please use the back of this sheet)

Briefly share what precipitated your decision to enter counseling at this time: _____

_____

What problems are you currently experiencing that counseling will help with? _____

_____

What are your goals for change? _____

_____

**Previous counseling experience:**

Start/ End: _____ Satisfied with results?_____ Completed goals? _____

Number of Children: _____ Ages: _____

Others living with you: _____

_____

If in a relationship, on a scale of 1 – 10, how would you rate your relationship? _____

What significant life changes or stressful events have you experienced recently: _____

_____



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Therapist and Personal Coach

**General Medical History:**
Any significant health issues at this time: ☐ yes ☐ no

Your physical health, at this time: ☐ Poor ☐ Fair ☐ Good ☐ Excellent MEDIC ALERT: ☐ yes ☐ no

Date of last health check-up: _____

Personal Physician (Optional):_____Phone:_____

Medical issues requiring treatment in the last 12 months: _____

Ever had a traumatic head/brain injury (TBI)? _____

Are you satisfied with your current level of:

Sleep: ☐ yes ☐ no Exercise: ☐ yes ☐ no Appetite: ☐ yes ☐ no Recreation: ☐ yes ☐ no

Are you taking any medications? ☐ yes ☐ no

If so, what_____

List allergies to drugs or medications:_____

**General Mental Health:**
Are you currently experiencing ☐sadness ☐ depression ☐ grief? If so: How long? _____

Are you currently experiencing ☐anxiety☐ panic attacks ☐ phobias? If so: How long? _____

Are you currently experiencing any chronic pain? ☐ yes ☐ no If so: How long? _____

History of suicidal/harm to self: _____

History of psychiatric hospitalizations: _____

**Family Mental Health History**:
In this section, identify if there is a family history of any of the following:

| | | | |
|---|---|---|---|
| Alcohol/Substance Abuse | ☐ yes ☐ no | Obesity | ☐ yes ☐ no |
| Anxiety | ☐ yes ☐ no | Obsessive Compulsive Behavior | ☐ yes ☐ no |
| Depression | ☐ yes ☐ no | Schizophrenia or Bipolar | ☐ yes ☐ no |
| Domestic Violence | ☐ yes ☐ no | Suicide Attempts | ☐ yes ☐ no |

**Alcohol/ Substance Use:**

Describe your use of alcohol:

Occasional: ☐ _____# of times a year. How many drinks: _____

Socially: ☐ _____ # of times per month. How many drinks: _____

Weekly: ☐ _____# of drinks in a week. How many drinks: _____

Daily Use: ☐ _____# of drink per day. How many drinks: _____

Do you use illicit/recreational use of drugs? ☐ no ☐ yes Substance used: _____

Occasional: ☐ _____# of times a year. How much: _____

Socially: ☐ _____ # of times per month. How much: _____

Weekly: ☐ _____# of times in a week. How much: _____

Daily Use: ☐ _____# of times per day. How much: _____

Do you use tobacco products? ☐ yes ☐ no Smoke: ☐ yes ☐ no Chew: ☐ yes ☐ no

**Additional Information:**

Are you employed? ☐ yes ☐ no If so, do you enjoy your work? ☐ yes ☐ no

If not, what would you like to change about your current employment situation? _____

_____

Do you consider yourself a spiritual person? ☐ yes ☐ no

If so, describe your faith or belief: _____

_____

What do you consider some of your strengths to be? _____

_____

What do you consider some of your challenges to be? _____

_____

Does your life have meaning and purpose? ☐ yes ☐ no What gives it meaning and purpose?

_____

Is there anything else you would like me to know at this time? _____

_____