

CLIENT INTAKE ASSESSMENT

CLIENT NAME: _____ DATE: _____

PRESENTING PROBLEM

Why are you seeking counseling ?

ENVIRONMENT

Where were you born? _____

What sort of dwelling do you currently occupy? _____

Own or rent? _____ How long have you lived there? _____

With whom do you live? _____

SPIRITUAL/CULTURAL

Current Faith/Practice _____ How Long: _____

Do you identify with a particular culture that guides your day-to-day life? _____

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FAMILY

	NAME	AGE
BIOLOGICAL/STEP MOTHER		
BIOLOGICAL/STEP FATHER		
SIBLING		
SIBLING		
SIBLING		
SIBLING		
SIBLING		
SIBLING		

Did you witness or experience any physical, emotional, or sexual abuse when you were growing up? Y N

Did anyone in your family have a substance abuse problem or chronic mental or physical illness or disability? Y N

CURRENT AND/OR LAST 3 SIGNIFICANT PARTNERS

NAME OF PARTNER	MONTH & YEAR MET	THEIR AGE	HOW MET	HOW LONG TOGETHER	MARRIED (Y or N)

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CHILDREN

NAME OF CHILD	AGE	BIO OR STEP	OTHER PARENT

EDUCATION

	NAME OF SCHOOL	DEGREE, CERTIFICATE, OR HIGHEST GRADE	YEAR GRADUATED
HIGH SCHOOL			
COLLEGE			
OTHER			

VOCATION

	NAME OF COMPANY	JOB TITLE OR DUTIES	HOW LONG THERE	REASON FOR LEAVING
CURRENT JOB				
FAVORITE JOB				
MILITARY SERVICE				

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MEDICAL

MAJOR OR CHRONIC PROBLEM/EVENT: Surgery, Diabetes, High Blood Pressure, Cancer, STD, HIV, Hepatitis, Head Injury, Neurological or Sensory Problems	YOUR AGE	MEDICATION PRESCRIBED	RUNS IN FAMILY (Y or N)

MENTAL HEALTH

PROBLEM OR DIAGNOSIS	AGE OF ONSET	RECEIVED TREATMENT?	RECEIVED MEDICATION?

Have you ever practiced self-injurious behavior, such as cutting or scarring? Y N

Have you ever thought about or attempted suicide? Y N

Have you ever thought about or attempted homicide? Y N

CRIMINAL OFFENSES

MONTH & YEAR	OFFENSE	LEGAL CONSEQUENCES

Have any restraining orders or orders of protection ever been put out against you? Y N

Have there ever been any domestic incidents involving police, but no one was arrested? Y N

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SUBSTANCE ABUSE & BEHAVIORAL COMPULSIONS

NAME OF SUBSTANCE	AGE OF 1 ST USE	AGE OF LAST USE	AGE OF PEAK USE
MARIJUANA			
COCAINE, CRACK			
<u>STIMULANTS:</u> METHAMPHETAMINE, ICE, DEXEDRINE			
<u>DEPRESSANTS & OPIATES:</u> VALIUM, QUAALUDE, PCP, ROCHES, HEROIN, CODEINE, MORPHINE, PERCOCET			
HALLUCINOGENS & CLUB DRUGS			
<u>INHALANTS:</u> GLUE, WHITE OUT, PAINT THINNER			
ALCOHOL			

Have you ever felt out of control with a behavior, like gambling, spending, work, exercise, sex, eating, dieting, cleaning, etc.? Y N

PREVIOUS TREATMENT or COUNSELING

TYPE	YEAR	WHERE	USEFUL KNOWLEDGE GAINED

Client Signature

Date

Lova G. Njuguna MC, NCC LPC
Pima Counseling LLC

Date