JAMES FAUST
& ASSOCIATES • PLLC
COUNSELING • COACHING • TRAINING

Client Intake Form

Name_____ Date_____

Address_____ City_____ Zip_____

Home Phone_____ Cell Phone_____

E-Mail Address_____ Gender: Male___ Female___

Date of Birth_____ Social Security No._____

May I leave you a message? Home Phone___ Cell Phone___ E-Mail___ Text___

Medical History

Name of Primary Care Physician_____

Physician Address_____ Telephone_____

Many managed care organizations require that we have interaction with the client's physician to coordinate care. Do we have your permission to discuss your care with the above listed physician?
Yes_____ No_____

Please sign here for either answer_____

Current medications:

1) _____ Dosage/Frequency _____Start Date _____

2) _____ Dosage/Frequency _____Start Date _____

3) _____Dosage/Frequency _____Start Date _____

4) _____Dosage/Frequency _____Start Date _____

Prescribed by_____

Have you ever been hospitalized for medical or psychiatric reasons? Yes ____ No ____

Hospital	Month/Year	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medical History Continued:

Please describe any important medical history, chronic ailments, or other health problems you have:

_____

_____

_____

_____

_____

Please describe any other health problems, psychiatric conditions, or important medical history of your immediate family or close relatives:

_____

_____

_____

_____

_____

_____

_____

If you are age 13 or older you have privilege over your medical and psychological history. This means that any statements made by you during the course of therapy are confidential and can only be shared with others with your permission. The only exceptions to this are if you intend you harm yourself or someone else, child abuse (abuse being done to you or by you, or to another person under the age of 18), or abuse of a vulnerable adult. It is sometimes useful if I can share your therapy progress with your parents or guardians, however this is entirely up to you.

Do I have permission to share your progress in therapy. ____Yes ____No If yes, please indicate who I may share this information with:

____Mother ____Father ____Step-Parent ____Other (please list)_____

_____ _____ _____

Signature Print your name Date

Social History

Who may I contact in case of emergency?

Name:_____ Phone_____ Relationship_____

Do you experience any academic problems while in school?

Yes_____ No_____ If yes, please explain:_____

_____

_____

What was the last year of school you completed? _____ What school are you attending now?

_____Grade / Year_____

_____

How would you describe your current support network, i.e., friends, relatives, etc.: _____

_____

Please check all information which applies to your biological parents:

Mother	____ living	Father	____ living
	____ deceased		____ deceased
	____ married		____ married
	____ divorced		____ divorced
	____ remarried ____ # times		____ remarried ____ # times

Do you consider someone else (step-parent, grandparent, etc.) to be your “real” parent? If so, please explain:_____

With whom do you live now? _____

Describe your relationship with your mother while growing up: _____

_____

Currently: _____

_____

Social History Continued:

Describe your relationship with your father growing up: _____

_____

Currently: _____

_____

Describe any family problems which occurred while growing up related to alcohol/drug abuse or problem gambling: _____

_____

_____

Physical / sexual / or emotional abuse: _____

_____

_____

Please list the names and ages of your siblings.

Name	Age	Relationship (natural, step, half, etc.)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Others living at home with you:

Name	Age	Relationship	Grade/Occupation
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Mental Status

Please check any of the following that describe how you have been feeling lately:

___sad ___anxious ___depressed ___frightened ___guilty ___angry ___ashamed ___aggressive

___resentful ___worthless ___tearful ___irritable ___confused ___extreme ups and downs

___jealous ___hopeless ___helpless

Describe any other feelings you have: _____

_____

Please check any of the following risk-taking behaviors you have engaged in:

___ street racing ___ gang involvement ___skip school ___ dropped out ___ cutting ___

___ dangerous dieting ___stealing ___ unprotected sex ___running away ___ bullying others

___ fire starting ___hurt animals ___restrict or restricted eating ___over exercise ___ gambling

Please check any of the following alcohol / drugs that you are currently or have previously used:

___ beer ___ Wine ___ hard liquor ___ pot ___ cocaine ___ heroin ___ Ecstasy ___ speed

___ over-the-counter drugs ___ prescription drugs ___ other (please list) _____

_____

Have you had any change in sleeping habits? ___Yes ___No If yes, describe:_____

_____

Have you had a change in eating habits? ___Yes ___No If yes, describe:_____

_____

Have you ever considered suicide in connection with your current problem? ___Yes ___No

If yes, is it just an idea, or have you made a plan on how to kill yourself? ___Yes ___ No

If yes, please describe:_____

_____

Have you ever considered suicide in the past? ___Yes ___No If yes, please explain:_____

_____

_____

Mental Status Continued:

Have you attempted suicide recently or in the past? ___Yes ___No If yes, please briefly explain with dates:_____

_____

Have you had any homicidal thoughts recently or in the past? ___Yes ___No If yes, please explain the circumstances:_____

_____

_____

Level of Functioning

List or describe any current impediments or problems in daily psychological, social or occupational functioning (i.e. isolation from friends/family, significant difficulty getting to work or school, completing daily tasks, severe financial strain, recent divorce, and problems with teacher, supervisor, etc.):

_____

_____

_____

Thoughts

Please check any of the following that apply to me:

____ I sometimes hear voices even though no one nearby is talking to me.

____ I sometimes feel forces outside of me control me.

____ I sometimes feel other people control my thoughts.

____ I sometimes have the same thought over and over an cannot control it.

____ I sometimes feel someone is out to hurt me or do something against me.

____ I sometimes cannot control my behavior. Please explain:_____

_____

_____

_____

Mental Status continued:

What activities or hobbies do you participate in? _____

_____

Do you participate in regular exercise? ____ Yes ____ No If yes please describe: _____

_____

_____

How much time do you spend online or gaming? _____

_____

Is there any other information regarding you or your family that you would like to share with your Therapist that is not covered on this form? You may also use this space to complete earlier responses.

_____

_____

_____

_____

Please list your therapy goals:

_____

_____

_____

_____

Thank you!

History completed by: ____Client ____Parent/Guardian ____Both ____Other (please describe)_____

_____ _____

Client Signature Date