### Client Intake Form

It is my desire to speak with you as soon as possible. In order to do this most efficiently, please fill out the following form, which will help me assess how to best work with you and your concerns. When you are finished please either bring this form to your first session or mail it back. Thank You.

# Demographic Information:

|  |  |  |  |
| --- | --- | --- | --- |
| **Name:** |  | **Birth-date:** |  |
| **Street Address:** |  |
| **City:** |  | **State:** |  | **Zip:** |  |
| **Phone #1:** |  | **Phone #2:** |  |
| **E-mail #1:** |  | **E-mail #2:** |  |
| **Marital Status:** | Single | Engaged/Married | Separated | Divorced | Widowed |
| **How did you hear about Luminance MHC/Carl Binger?:** |  |
| **Is there a specific day/time that is best for you to come to counseling?** |  |
| **Who should be contacted if an emergency arises?** | **Name:** |  |
| **Phone:**  |  | **Relationship:** |  |

# Clinical Information:

**In your own words, what has motivated you to come to counseling now?**

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# Concern Checklist: *Listed below you will find a list of problems people commonly face. This list surveys family, academic, social, spiritual, and other problems of everyday life. Read the list carefully and circle the item(s) that are causing you the most trouble at this time.*

|  |  |  |  |
| --- | --- | --- | --- |
| **Anxiety** | Sadness | Fears | **Substance Use** |
| Bad dreams/Nightmares | Afraid of hurting self | Fear of death | Difficulty quitting addiction |
| Being overly excited | Difficulty concentrating | Fear of the failure | Drinking too much alcohol |
| Difficulty relaxing | Feeling overly emotional | Fear of future | Fear of overdosing |
| Feeling nervous | Feeling depressed | Fear of people | Smoking too many cigarettes |
| Racing thoughts | Suicidal thoughts/behaviors | Irrational fears | Using drugs |
| Parents | **Finances** | Feelings | Spirituality |
| Difficulty talking with parents | Can’t make ends meet | Feeling anxious | Afraid God will punish me |
| Parents constantly arguing | Can’t decide on career | Feeling guilty | Confusion about God |
| Parents being too strict | Spending money foolishly | Feeling inferior | Feeling unaccepted by God |
| Parents interfering with life | Unable to find job | Feeling lonely | Failure with God |
| Parents Separated/Divorced  | Worried about finding job | Feeling no one likes me | Feeling abandoned by God |
| Poor relationship with parents | Worries about money | Feeling sad | Inability to get to church |
| Anger | Friends | Health | **Self-Esteem** |
| Difficulty loosing temper | Death of close friend | Anorexia | Being overweight |
| Fear that I might hurt someone | Difficulty getting close w/ others | Bulimia | Being underweight |
| Feeling jealous | Friend emotionally upset | Headaches | Being noticed for physical appearance |
| Getting into arguments | Friend attempting suicide | Lack of Energy | Eating too much |
| Getting into fights | Friend committing suicide | Lack of Sleep | Feeling unattractive |
| Hurting other’s feelings | Friend with serious illness | Racing heart | Hating Self |
| Inability to express anger | Missing good friend(s) | Serious Illness | Identity Issues |
| Upset about past hurts | Picking the wrong friends | Stomachache/ulcer | Poor eating habits |
| Social Situations | Sexuality | Work | Guilt |
| Awkward meeting new people | Concern about sexual orientation | Difficulty with supervisor | Being careless |
| Being criticized by others | Dating issues | Difficulties with work load | Cheating  |
| Being left out of things | Difficulties with sexual thoughts | Feeling out of place  | Feeling ashamed of something |
| Critical of others | Difficulty getting dates | Financial worries | Getting into trouble |
| Difficulty making friends | Difficulties with sexual behavior | Getting low/failing grades | Giving into temptation |
| Having a bad attitude | End of relationship | Performance issues | Involved in sexual relationship |
| Having few hobbies | Involved in bad relationship | Missing work due to illness | Lacking self-control |
| Having strong opinions | Memories of past sexual abuse | Not in right job | Not being honest with others |
| Having little/no opinions | No sexual thoughts/behaviors | Overloaded with work | Not taking things seriously  |
| Lacking self-confidence | Questions about sex | Poor memory for work | Stealing from others |
| Lack of interest in activities | Uncomfortable with other sex | Poor work habits | Unable to stop bad habit |
| Uncomfortable in situations | Sexually underdeveloped | Unable to concentrate on work | Use of pornography |
| Wish people liked me better | Wondering about marriage | Worries about performance | Unexpected Pregnancy |
| Family | Other | **Other Continued** | **Other (Please specify):** |
| Death of family member | Acting strangely | Hearing voices |  |
| Difficulty with brother/sister | Compulsive behaviors | Involved in abusive situation |  |
| Family member with illness | Difficulties with reality | Little or no emotion |  |
| Family member loosing job | Family history of mental illness | Loosing portions of time |  |
| Feeling homesick | Feeling strange | Obsessive thoughts |  |
| Poor relationship with family | Gender confusion | Self-Harming behaviors |  |

**In your opinion, which of the following is most applicable?**

 This is a concern that would probably be resolved with one meeting. It is just a consultation or discussion to get some input from a third

 party. I’d like to see someone as soon as possible, but this isn’t an emergency.

 This is a concern that will probably require several sessions. I’ve been thinking about it for a while. I’d like to start as soon as possible (within

 one to two weeks).

 This is a concern that will probably require several sessions. The situation is urgent; I need to speak with someone within the next 24 hours.

I give Carl Binger of Luminance Mental Health Counseling consent to provide Mental Health Counseling to myself, or my child:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Print Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sign Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date