RINER COUNSELING, LLC

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Client Intake Information

Today's Date: _____

Client's Name: _____ Date of Birth: _____ Age: _____

Local Phone: _____ Local Address: _____

Emergency Contact Name/Number:

_____

Relationship Status: **Married** (No. of years): ____ **1st Marriage**___ **2nd**____ **Single**:____ **Separated** (since): _____
Divorced (since when): ____ **Living together, Not Married:** _____

Sexual Identity: **Heterosexual**: ____ **Gay** ____ **Lesbian**:____ **Bisexual**: _____ **Queer**: ____ **Other:** _____

Race/Ethnicity: **Asian**: ____ **Black/African American:** ____ **Hispanic/Latino**:____ **Caucasian**: _____ **Other**: ____

Education: Major: _____ Degree: _____ Employment: _____

Do you identify with a particular religion? **Yes**____ **No**____

Please describe your main reasons for making an appointment.

_____

_____

_____

_____

_____

_____

Please list your immediate family members:

Name - Relationship	Age and Sex	Education/Occupation

Family History and Background

Where were you born? _____

Briefly describe your childhood: _____

Have you ever had a history of: ABUSE/TRAUMA ____ ABANDONMENT _____ LEGAL ISSUES _____
SCHOOL/Academic PROBLEMS _____ Prior Hospitalization _____

Briefly describe your family members:

Mother:_____
Father:_____
Brothers:_____
_____
Sisters:_____
_____

How does your family communicate?

_____

How is affection shown in your family? _____

How did your mother discipline you?

_____

How did your father discipline you?

_____

What would you change about your family?

_____

_____

Medical/Mental Health History

Name of Primary Physician: _____ **Phone #:** _____

List any medical conditions: _____
_____

Are you currently taking any medications? YES _____ NO _____
If so, please identify medication, dosages, and times taken: _____
_____

List any anti-depressants or similar medications you have taken in the past: _____
_____

Are you allergic to any medications? YES _____ NO _____
If yes, what are they? _____

Have you had previous therapy/psychiatric services? YES _____ NO _____
If yes, name of provider, length, and reasons for treatment? _____
_____

What are your goals you hope to achieve through counseling? _____
_____
_____
_____
_____
_____
_____
_____

Presenting Problem Areas (Please Circle all that are all applicable to you):

Self Esteem
Drug or Alcohol Abuse
Relationships/Marital/Family/Children
Eating Disorder/Body Image
Anger
Financial
Depression
Anxiety
Health
Trauma
Spiritual
Grief
Sexual
Transitions/Coping
Self-Harm/Self-Injury
Suicidal Ideation
Homicidal Ideation

Adult Checklist of Concerns

	I have no problem or concern		Impulsiveness (e.g., spending $)		Self-abuse – other
	Abuse – emotional		Indecision		Self-abuse – scratching
	Abuse - neglect		Inferiority Feelings		Self-centeredness
	Abuse – physical		Inhibitions		Self-control
	Abuse – sexual		Interpersonal Conflicts		Self-esteem
	Aggression		Irresponsibility		Self-neglect
	Anger		Irritability		Separation
	Anxiety		Judgment Problems		Sexual Conflicts
	Arguing		Laziness		Sexual Desire Differences
	Attention Problems		Legal Matters		Sexual Dysfunction
	Career Concerns		Loneliness		Sexual – other issues
	Childhood Issues		Loss of Control		Shyness
	Children – care of		Losses		Sleep – insomnia
	Children – custody		Low Energy		Sleep – nightmares
	Children – management		Low Frustration Tolerance		Sleep – too little
	Codependence		Low Income		Sleep – too much
	Compulsive Spending		Low Mood		Step-parenting
	Concentration Problems		Marital Coldness		Stress
	Confusion		Marital Conflict		Stress-management
	Crying		Marital Distance		Suicidal Thoughts
	Deaths		Marital Infidelity/Affairs		Suspiciousness
	Debt		Medical Concerns		Temper Problems
	Decision Making		Memory Problems		Tension/Stress
	Delusions – false ideas		Menopause		Thought Disorganization
	Dependence		Menstrual Problems		Threats of Violence
	Depression		Mixed Feelings		Tiredness
	Distractibility		Mood Swings		Tobacco Use
	Divorce		Motivation		Violence
	Drug abuse – over the counter		Mourning		Violence – victim of crime
	Drug abuse – prescription		Obsessions		Work Problems
	Drug abuse – street drugs		Outbursts		Weight and Diet Issues
	Drug abuse – alcohol		Oversensitive to Criticism		Withdrawal – isolating
	Eating – poor appetite		Oversensitive to Rejection		Employment Problems
	Eating – making myself vomit		Panic or Anxiety Attacks		Employment – lack of
	Eating – overeating		Parenting		Employment – overdoing
	Eating – under-eating		Perfectionism		Employment – termination
	Emptiness		Pessimism		**Other Concerns or Issues:**
	Failure		Phobias		
	Fatigue		Physical Problems		
	Fears		PMS		
	Financial Troubles		Poor Self-Care		
	Friendship Problems		Procrastination		
	Gambling		Relationship Problems		
	Goals Not Being Met		Relaxation		
	Grieving		Re-marriage		
	Guilt		Risk Taking		
	Headaches, Pains		Sadness		
	Health		School Problems		
	Hostility		Self-abuse – burning/cutting		

SUBSTANCE USE HISTORY

How often do you use: Please describe your number of usages, frequencies (daily/monthly), and amount consumed.

Alcohol _____

Cocaine _____

Hallucinogens (i.e. LSD) _____

Inhalants (i.e. paint) _____

Marijuana _____

Methamphetamine _____

Narcotics (i.e. heroin) _____

Tobacco _____

Coffee/Soda _____

Have you ever received substance abuse treatment of any kind before? Y N

Have you ever felt you had a problem with, or ought to cut down on, your drinking or drug use? Y N

PLEASE INDICATE HOW YOUR PROBLEMS ARE AFFECTING THE FOLLOWING AREAS:

	No Effect				**Significant Effect**	
Marriage/relationship	1	2	3	4	5	N/A
Family	1	2	3	4	5	N/A
Job/School Performance	1	2	3	4	5	N/A
Friendships	1	2	3	4	5	N/A
Hobbies	1	2	3	4	5	N/A
Financial Situation	1	2	3	4	5	N/A
Physical Health	1	2	3	4	5	N/A
Anxiety Level/Nerves	1	2	3	4	5	N/A
Mood	1	2	3	4	5	N/A
Sexual Functioning	1	2	3	4	5	N/A
Ability to Concentrate	1	2	3	4	5	N/A
Ability to Control Temper	1	2	3	4	5	N/A
Spirituality	1	2	3	4	5	N/A
Eating Habits	1	2	3	4	5	N/A