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DAYBREAK COUNSELING P.C.
...defining hope

CLIENT INTAKE INFORMATION

A. PERSONAL INFORMATION

Name: _____ Date _____

Address: _____ City: _____

State: _____ Zip: _____

E-mail: _____

Sex: _____ Age: _____ Birth Date: _____

Phone Numbers:
Home: _____ Work: _____ Cell: _____

Spouse or Partner's Name: _____

Why are you currently seeking counseling? _____

_____

What goals do you hope to accomplish during counseling? _____

_____

What do you need in order to live the life you want to live? _____

_____

Who referred you to me? _____

May I thank the referral person/agency? _____

Do you have a current church or spiritual affiliation?_____

_____

B. INSURANCE INFORMATION

Payment will be covered by:
Health Insurance: Yes / No Patient: Yes / No Other: _____

Insurance Company: _____

ID# _____ Group# _____

Phone Number for Provider: _____

C. EMPLOYMENT / EDUCATION INFORMATION

Occupation_____ Employer:_____

Hours:_____ Approx. Years Employed: _____

Highest level of education achieved: _____

Any degrees? If so, in what area? _____

Military: _____ Any special vocations? _____

D. PRESENT LIFE SITUATION

1.Marital Status:

❏ Single

❏ Legally Married
date: _____

❏ Divorce In Progress

❏ Separated
date: _____

❏ Widowed
date: _____

❏ Divorced
date: _____

❏ Live In Partner
date: _____

❏ Other_____

2. Children:

Name	DOB	Significant Information

3. Other persons living in your home: _____

_____

4. Describe the atmosphere of your home: (calm, chaotic, busy, etc.) _____

_____

_____

5. Current leisure and recreation activity(s): _____

_____

6. Significant life events: (illness, death, job change, baby, etc.) _____

_____

E. HEALTH HISTORY

1. Known / Suspected Physical Problems:

- ❑ Ulcers
- ❑ Allergies
- ❑ Diabetes
- ❑ Seizures or Epilepsy
- ❑ Fainting / Dizzy Spells
- ❑ High / Low BP
- ❑ Thyroid Problems
- ❑ Vision / Hearing Problems
- ❑ OB/GYN Concerns
- ❑ Colitis, Crohns Disease, or Gastrointestinal Problems
- ❑ Other (Please List) _____

2. Recent Changes In:

- ❑ Sleep Patterns
- ❑ Eating Patterns
- ❑ Energy Level
- ❑ Physical and/or Sexual Activity Level
- ❑ Weight
- ❑ General Behavior

3. Physicians: _____

4. Date and prognosis of last physical: _____

_____

5. Chemical use history: *(Previous and current use, drug of choice, impact of functioning, last use, relapse, recovery, verdose history, and perception of problem)* _____

_____

6. Have you had previous counseling? _____

When? _____ Where? _____

What were you seen for? _____

Did you receive a formal diagnosis? _____

If yes, please indicate: _____

Was your counseling experience positive or negative? _____

If negative, please explain: _____

F. FAMILY OF ORIGIN

❑ Parents Legally Married

❑ Parents Separated
date: _____

❑ Parents Divorced
date: _____

❑ Father Remarried
date: _____

❑ Mother Remarried
date: _____

❑ Father Widowed
date: _____

❑ Mother Widowed
date: _____

1. Mother's name, age, occupation: _____

_____

2. Father's name, age, occupation: _____

_____

3. Siblings

Name	DOB	Marital Status	Occupation	Children	Location

5. Other significant relationships: (family or other) _____

_____

6. Important social relationships: (clubs, church, sports, etc) _____

_____

7. Do I need to be aware of any cultural / ethnic differences? _____

_____

8. Have you been sexually, physically, or verbally abused by a family member or someone you know? _____

_____

G. MENTAL STATUS

Are you experiencing any of the following?

- ❑ Guilt
- ❑ Passivity
- ❑ Mood swings
- ❑ Anxiety
- ❑ Poor concentration
- ❑ Insomnia / Hypersomnia
- ❑ Anger
- ❑ Binging / purging
- ❑ Serious thoughts of harming others
- ❑ Paranoia
- ❑ Low self-esteem
- ❑ Memory difficulty
- ❑ Hallucinations
- ❑ Panic attacks
- ❑ Over / under eating
- ❑ Depression
- ❑ Suicidal thoughts
- ❑ Chronic pain
- ❑ Suicide attempts: Describe when, method of attempt(s), number of times, how rescued: _____

_____

_____

Thank you for your time and cooperation in filling out this lengthy intake. Please be assured that the information will help in formalizing our counseling sessions for the best treatment possible.

_____ _____

Client or Guardian Signature (if under 18) **Date**

_____ _____

Therapist's Signature **Date**