



TOTAL LIFE COUNSELING

Client Intake Form

Please provide the following information for our records. Leave blank any questions you would rather not answer. Information provided is held to the same standards of confidentiality as TLC's counseling services. The following is intended to give TLC a complete picture of your self-assessed emotional wellness and your self-directed goals for counseling. This form is not intended to assess, diagnose, or treat any specific medical or psychological condition.

Name: _____

Guardian/Parent (if minor): _____

Client Date of Birth: ____/____/____ Age: ____ Gender: Male Female

HEALTH & SOCIAL INFORMATION

1. How is your physical health at present?

Poor Unsatisfactory Satisfactory Good Excellent

2. Please list any relevant and persistent physical symptoms or health concerns (e.g. chronic pain, headaches, high blood pressure, diabetes, etc...): _____

3. Are you having problems with sleep habits? Yes No

If "Yes," please check all that apply:

Not enough sleep Too much sleep Poor quality of sleep Disturbing dreams

Other: _____

4. How many times per week do you get exercise? _____

For how long each session do you exercise? _____

5. Are you having difficulty with eating habits? Yes No

If "Yes," please check all that apply:

Eating less than usual Eating more than usual Binging Loss of interest in food

Unhealthy foods Other: _____

6. Do you regularly use alcohol? Yes No

If "Yes," in a typical month, how often do you have 4 or more drinks in a day? _____

7. Do you engage in recreational drug use (including marijuana)? Yes No

If "Yes," how often?

Several times daily Daily Weekly Monthly Rarely

8. Have you had thoughts of suicide? Yes No

Frequently Occasionally Recently In the past (how long ago? _____)

9. Are you currently in a romantic relationship? Yes No

If "Yes," how long have you been in this relationship? _____

On a scale of 1 to 10, how would you rate this relationship? _____

10. Please list any major life changes or stressors you have experienced in the past year:

11. Have you EVER experienced:

- | | |
|------------------------------------------------------------------------|---------------------------------------------------------------|
| <input type="checkbox"/> Extreme mood swings | <input type="checkbox"/> Alcohol / substance abuse |
| <input type="checkbox"/> Extreme depression for more than a few days | <input type="checkbox"/> Chronic or frequent physical illness |
| <input type="checkbox"/> Severe anxiety / Panic attacks | <input type="checkbox"/> Eating disorder |
| <input type="checkbox"/> Paranoia | <input type="checkbox"/> Body image problems |
| <input type="checkbox"/> Phobias | <input type="checkbox"/> Obsessive thoughts |
| <input type="checkbox"/> Sleep disturbances | <input type="checkbox"/> Homicidal thoughts |
| <input type="checkbox"/> Hallucinations (auditory, visual, or tactile) | <input type="checkbox"/> Suicidal thoughts |
| <input type="checkbox"/> Unexplained gaps in memory / losses of time | <input type="checkbox"/> Suicide attempts |

OCCUPATIONAL INFORMATION

12. Are you currently employed? Yes No

If "Yes," how long have you been at your current job? _____

If "Yes," are you happy in your current position? Yes No

If "Yes," on a scale of 1 to 10, how stressful is your current job? _____

SPIRITUAL / RELIGIOUS INFORMATION

13. Do you consider yourself to be religious? Yes No

If "Yes," what religion or denomination do you belong to? _____

14. Do you attend church regularly? Yes No

15. Is your church community an important part of your daily social life? Yes No

FAMILY HISTORY

16. Are you aware of any member of your immediate or extended family who has experienced difficulties with any of the following:

Depression Family Member: _____

Bi-polar Disorder Family Member: _____

Anxiety Disorders Family Member: _____

Panic attacks Family Member: _____

Schizophrenia Family Member: _____

Alcohol / substance abuse Family Member: _____

Eating disorders Family Member: _____

Learning disabilities Family Member: _____

Suicide / Suicide attempts Family Member: _____

OTHER INFORMATION

17. What do you consider to be your strengths? _____

18. What do you like most about yourself? _____

19. What are some of the things you do to cope with stress? _____

20. What are your goals for counseling? _____
