ALISON W. SORENSON, MS, LPC
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Client Intake Form

First Name _____ MI _____ Last Name _____ Maiden _____

Age _____ Date Of Birth _____ Gender: __ ___ _____

Ethnicity
- ☐ Asian/Pacific Islander
- ☐ American Indian
- ☐ International Student Country: _____
- ☐ White
- ☐ Hispanic
- ☐ Black

Relationship Status
- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Engaged
- ☐ Separated
- ☐ Widowed

Mailing Address	City	State	Zip

Phone	Email Address
☐ Yes, you can leave a message or text.	☐ Yes, you can leave an email.

Name of Insurance	Insurance Address	Insurance Phone	Policy #

Policy Holders Name	SSN	Birth Date	Effective Date

Please indicate who referred you

Referral Type ☐ Self ☐ Family ☐ Friend ☐ Healthcare Provider ☐ Other

Please read the following questions and mark those to which you would respond "yes."

- ☐ Have you previously been involved in counseling?
- ☐ Do you currently use alcohol or other non-prescription drugs?
- ☐ Is there a history of mental health problems in your family?
- ☐ Have you ever been physically abused?
- ☐ Have you ever been emotionally abused?
- ☐ Have you ever attempted suicide?
- ☐ Have you ever been hospitalized for mental health reasons?
- ☐ Is there a history of alcohol or drug problems in your family?
- ☐ Have you ever been in legal trouble?
- ☐ Have you ever been sexually abused or assaulted?
- ☐ Are you currently taking any prescription medications?
- ☐ Are you harming, or you feel you may harm, yourself or another(s)?

Please describe the concerns you would like to discuss:

How long has this problem persisted?	Under what condition do your problems get worse? better?

How would you know after today if counseling was helpful?

Please use the following scale to answer the next three questions:	1 Not at all	2 Mildly	3 Moderately	4 Highly
1. How serious do you consider your present concern(s)?	☐	☐	☐	☐
2. How motivated are you to resolve your concern(s)?	☐	☐	☐	☐
3. How optimistic are you that your concern(s) can be managed?	☐	☐	☐	☐

Family History

Mother's Age _____ If deceased, how old were you when she died? _____

Father's Age _____ If deceased, how old were you when he died? _____

If your parents are separated, how old were you then? _____

Number of brother(s) _____ What are their ages? _____ _____ _____ _____

Number of sister(s) _____ What are their ages? _____ _____ _____ _____

If you were adopted or raised with parents other than your natural parents please explain:

Briefly describe your mother's personality:

Briefly describe your father's personality:

Briefly describe your stepparent(s) personality:

Briefly state positive and negative events during the ages of:

0-5 years	12-18 years
6-11 years	Adult years

Anything else you would like me to know about you, or would like me to be sure and ask:

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Please mark all of the following that apply **now** or ever in your **past**

Feelings

- ☐ Helpless
- ☐ Depressed
- ☐ Shameful
- ☐ Angry
- ☐ Guilty
- ☐ Hopeless
- ☐ Lonely
- ☐ Sad
- ☐ Stressed
- ☐ Unhappy
- ☐ Other _____
- ☐ Anxious
- ☐ Out of Control
- ☐ Afraid
- ☐ Numb
- ☐ Relaxed
- ☐ Happy
- ☐ Excited
- ☐ Hopeful
- ☐ Inferiority Feeling
- ☐ Mood Shifts

Thoughts

- ☐ Confused
- ☐ Unintelligent
- ☐ Worthless
- ☐ Unmotivated
- ☐ Unattractive
- ☐ Unlovable
- ☐ Confident
- ☐ Worthwhile
- ☐ Homicidal
- ☐ Other _____
- ☐ Racing
- ☐ Obsessive
- ☐ Distracted
- ☐ Disorganized
- ☐ Paranoid
- ☐ Suicidal
- ☐ Sensitive
- ☐ Honest

Symptoms/Behaviors

- ☐ Eating Less
- ☐ Procrastinating
- ☐ Attempting Suicide
- ☐ Poor Concentration
- ☐ Crying
- ☐ Withdrawing Socially
- ☐ Skipping Classes
- ☐ Binge Drinking
- ☐ Injuring self
- ☐ Compulsivity
- ☐ Career/Major Choice
- ☐ Acting Out Sexually
- ☐ Acting Aggressively
- ☐ Disorganization
- ☐ Impulsivity
- ☐ Recklessness
- ☐ Irritability
- ☐ Passivity
- ☐ Drug Use
- ☐ Alcohol Use
- ☐ Being Good to Yourself
- ☐ Sexual Problems
- ☐ Socializing
- ☐ Marital Relationships
- ☐ Parent/Child Conflicts
- ☐ Lack of Ambition/Goals
- ☐ Poor Peer Relationships
- ☐ Night Mares
- ☐ Worries About Body Image
- ☐ Spiritual Problems
- ☐ Dating Concerns
- ☐ Finances
- ☐ Other _____

Physical Symptoms

- ☐ Insomnia
- ☐ Tired
- ☐ Weight Gain or Loss
- ☐ Pain
- ☐ Headaches
- ☐ Tightness In Chest
- ☐ Dizziness or Light-headedness
- ☐ Numbness or Tingling
- ☐ Vomiting
- ☐ Rapid Heart Beat
- ☐ Dry Mouth
- ☐ Excessive Sleep
- ☐ Loss of Memory
- ☐ Eating Problems
- ☐ Other _____

Please describe any medical conditions you have:

If you are currently taking any medication(s), please list the type, dosage, the purpose, and name of prescriber for each below: