Paraclete Services, LLC
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CLIENT INTAKE INFORMATION

(Please Print Unless Otherwise Specified)

Date: _____

1. Name: _____ Age: _____ Date of Birth: _____
(First) (Middle) (Last)
Phone: _____ Sex: M _____ F _____

2. **Medical**
Primary Care Provider / Clinic: _____ Phone: _____
Current prescription(s), over-the-counter medication(s), and/or dietary supplement(s):
*Dosage *Directions *Condition [for pain etc …] *Prescribing Provider

_____
_____
_____

Do you have, or have you ever had a side-effect, reaction and/or allergic reaction to any prescription medication, over-the-counter medication, and/or any dietary supplement(s): ( ) Yes ( ) No
List the medication(s) and/or dietary supplement(s), and the side-effect / allergy issue(s):

_____
_____
_____

3. **Mental Health**
Have you ever been in / participated in counseling before? ( ) Yes ( ) No
*When *From Whom (include profession) *Reason *Outcome

_____
_____

Have you ever been prescribed medication for an emotional or mental health reason? ( ) Yes ( ) No
*When *Prescriber *Medication *Reason *Outcome

_____
_____

Have you ever been hospitalized for an emotional, mental health or psychiatric reason? ( ) Yes ( ) No
*When *Doctor *Where *For What Reason *Outcome

_____
_____

4. **Alcohol and/or Drug**
Have you ever consumed alcohol? ( ) Yes ( ) No
Do you currently consume any alcohol? ( ) Yes ( ) No
At what age did you first drink alcohol? _____
Explain the kind of alcohol, and how and when you drank alcohol (*beer *wine *hard liquor):

_____
_____

Men: How many times in the past year have you had 5 or more drinks in a day?
( ) None ( ) 1 or more
Women: How many times in the past year have you had 4 or more drinks in a day?
( ) None ( ) 1 or more
What type of alcohol do you consume (Check all that apply):
( ) Beer ( ) Wine ( ) Hard Liquor

Have you ever smoked and/or used chew tobacco? ( ) Yes ( ) No
If **Yes**, at what age did you first start smoking and/or using chew tobacco? _____
Explain why you chose to smoke and/or use chew tobacco: _____

Have you stopped smoking and/or using chew tobacco? ( ) Yes ( ) No
If **Yes**, date: _____
Have you tried to quit smoking and/or using chew tobacco? ( ) Yes ( ) No
If **Yes**, date(s): _____
Do you currently **Smoke** or **Chew** tobacco? ( ) Yes ( ) No
If Yes, please indicate the: *Type of tobacco you use *How much you use *How often you use?
_____

Do you use any *recreational drugs, or use prescription medication for nonmedical reasons?
[*recreational drugs include methamphetamines (meth, speed, crystal), cannabis (marijuana, pot), inhalants (paint thinner, aerosol, glue), tranquilizers (valium), barbiturates, cocaine, ecstasy, hallucinogens (LSD, mushrooms), narcotics (heroin), spice, and/or bath salts]:
( ) Yes ( ) No

Name(s) of recreational drug(s) and/or prescription medication(s): _____
_____

How many times in the past year have you used a recreational drug, or used a prescription medication for nonmedical reasons? ( ) None ( ) 1 or more

During the past two weeks, have you been bothered by little interest or pleasure in doing things?
( ) Yes ( ) No
During the past two weeks, have you been bothered by feeling down, depressed, or hopeless?
( ) Yes ( ) No

Are you now, or have you ever been in alcohol and/or drug recovery, and /or in an alcohol and/or drug treatment program? ( ) Yes ( ) No ( ) In-patient ( ) Outpatient
*Where *How Long *Outcome
_____
_____

5. **Family Information**
Relationship Status: ( ) Single ( ) Married ( ) Divorced ( ) Widow/Widower ( ) Significant Other
If Married, or have Significant Other, length of relationship: _____

This is my: ( ) 1st ( ) 2nd ( ) 3rd ( ) 4th marriage / significant other relationship

List everyone who *lives with you *their relationship to you (husband/wife, daughter/son, identify other relationship), and their age:
_____

How do you get along with your *parent(s) *spouse / significant other *children *siblings? Explain:

_____

_____

Family history (please put a check mark on the short line to the left of the "issue", and indicate the family member's relationship to you on the line to the right of the "issue" (x Depression- brother):
__ Emotional Issues- _____ __ Anxiety- _____ __ Depression- _____
__ Other Mental Health Issues- _____ __ Alcoholism / Drug Addiction- _____

Please indicate death(s) of any family member(s): _____

6. **Seeking Counseling For**
Please describe the main reason(s) / concern(s) that prompted you to call PCS, and for how long you've been concerned:

_____

_____

_____

7. **Resources**
What kind of support system(s) do you have?

_____

_____
Does religion or spirituality play an important part in your life? Explain: _____

_____

_____

8. Describe what you consider to be your strengths, unique qualities, special gifting / abilities, etc …:

_____

_____
What types of activities and/or hobbies do you enjoy? _____

_____

The information I have provided in this Client Intake Information is complete, true and correct to the best of my knowledge.

Client Signature: _____ Date: _____
Printed Name: _____ Date of Birth: _____
Relationship to Subscriber: _____

Client Signature: _____ Date: _____
Printed Name: _____ Date of Birth: _____
Relationship to Subscriber: _____

(If Client is under 13 years old)
Parent / Guardian Signature: _____ Date: _____
Printed Name of Parent/Guardian: _____ Date of Birth: _____
Relationship to Client: _____

Counselor: _____ Date: _____