CMB COUNSELING LLC
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CONFIDENTIAL CLIENT INTAKE FORM

CLIENT INFORMATION

Name: _____

Date of Birth: _____ Age: _____ Gender: _____

Marital/Relational Status: _____ Partner/Spouse Name: _____

Children (Names and ages):
_____
_____
_____

Others living in your home:
_____
_____
_____
_____
_____

Occupation: _____ Highest Level of Education: _____

CLIENT CONTACT INFORMATION

Address: _____
_____
_____

Phone number(s): Home: _____ Cell: _____

At which number(s) may I leave a message?
_____

EMERGENCY CONTACT

Name: _____ Relationship to you: _____

Address: _____
_____
_____

Phone: Home: _____ Cell: _____

(Please continue on back)

PAST YEAR CHECKLIST

Only respond to those areas that apply to you. Please rate the level of distress these issues have caused you in the past year:

0	1	2	3	4
None	**Minor**	**Moderate**	**Considerable**	**Extreme**

_____ Sleeping too much/Too little
_____ Eating too much/Too little
_____ Mood Swings
_____ Angry Outbursts
_____ Depression
_____ Repetitive Behaviors
_____ Anxiety/Fear
_____ Lack of energy
_____ Hear/See things others cannot
_____ Suicidal Thoughts/Actions
_____ Physical/Emotional/Sexual abuse
_____ Drug/Alcohol (self or other)
_____ Loneliness
_____ Caring for others
_____ Distance from Loved Ones

_____ Death/Major Loss
_____ Past trauma
_____ Health Problems
_____ Sexual Problems
_____ Relationship Problems
_____ Concerns regarding family
_____ Education/Work Concerns
_____ Financial Concerns
_____ Legal Difficulties
_____ Major Life Transition
_____ Gender Identity Conflict
_____ Sexual Identity Conflict
_____ Cultural Concerns
_____ Religious Conflicts
_____ Experienced Discrimination

EXPECTATIONS FOR THERAPY

What brings you to seek therapy now and what do you hope to gain?

_____
_____
_____
_____
_____

What are your concerns about therapy?

_____
_____
_____
_____

Past experiences in counseling/therapy? Positive or Negative?

_____
_____
_____
_____

MEDICAL AND MENTAL HEALTH TREATMENT INFORMATION

Please describe your physical and mental health including significant hospitalizations, illnesses, and/or medications.

_____
_____
_____
_____
_____ **(over)**

Are you currently receiving other mental health services or medical treatments?

_____
_____
_____
_____

SAFETY ASSESSMENT

Have you ever given serious consideration to, or attempted to end your own life?

_____
_____

Last occurrence:

_____
_____

If yes, do you currently feel this way? Do you have a plan?

_____
_____
_____
_____

Have you ever given serious consideration to, or attempted to harm another person?

_____
_____

Last occurrence:

_____
_____

If yes, do you currently feel this way? Do you have a plan?

_____
_____
_____
_____

SUBSTANCE USE

Do you currently use tobacco, alcohol, or other drugs?

Substance	**How much and how often?**	**Past Use**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

(If applicable) When did/do you use the most:

_____
_____
_____

(over)

Past substance abuse treatment?

_____
_____
_____

LEGAL HISTORY

Are you involved in the legal system or have you had significant legal issues in the past?

_____
_____
_____
_____

FAMILY INFORMATION

Please give me a brief family history. Describe family of origin and your current family dynamics:

_____
_____
_____
_____
_____
_____
_____
_____

RELATIONSHIPS WITH OTHERS

Please describe the important people in your life and the quality of these relationships:

_____
_____
_____
_____
_____
_____
_____

Have you now or ever experienced violence, abuse, or threatening behavior in a relationship?

_____
_____
_____
_____
_____

Do you have any concerns related to gender identity or sexual identity?

_____
_____
_____
_____
_____

TRAUMA HISTORY

Please list any past traumatic experiences you have had (including but not limited to childhood abuse, military combat, assault, natural disasters, life threatening illness).

_____
_____
_____
_____ **(over)**

STRENGTHS AND RESOURCES

What helps you to make it through difficult times?

Who can you count on for support in times of need?

What gives you personal enjoyment?

Tell me about special skills or abilities that you have:

What communities are you a part of?

Do you have religious practices or spiritual beliefs that are important to you?

(over)

Please describe your cultural identity and how it is important to you:

_____
_____
_____
_____
_____
_____

What else should I know?

_____
_____
_____
_____
_____

Additional Notes: