Caitlin Connolly, MSW, LICSW
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Counseling Intake/Client History Information

Name/DOB _____ Social Security # _____

Street Address _____

City _____ State __ Zip _____ County _____

Cell Phone _____ext. ____ Other Phone _____ ext. ____

Emergency Contact _____ Phone _____ext. ____

Relationship _____Gross Monthly Income _____ Number in Family __

Ethnicity _____ Sexual Orientation _____

Current living arrangements _____

Is it okay to leave messages? ☐ Yes ☐ No

Therapy is to provide you an opportunity to focus on issues and problems that are important to you. To help me best serve you, please check any of the following topics which may be causing you problems.

1. ☐ Legal
2. ☐ Health
3. ☐ Education
4. ☐ Communication Skills
5. ☐ Life Planning/Goal Setting/Transitions
6. ☐ Self-Esteem/Assertiveness
7. ☐ Drugs or alcohol issues
8. ☐ Depression
9. ☐ Suicidal Thoughts
10. ☐ Work related issues
11. ☐ Anxiety/Social isolation
12. ☐ Mood Swings
13. ☐ Panic Attacks
14. ☐ Grief/Loss
15. ☐ Stress
16. ☐ Money Management
17. ☐ Phobia
18. ☐ Trauma
19. ☐ Parenting
20. ☐ Incest/Sexual Abuse
21. ☐ Domestic Violence
22. ☐ Divorce/Separation/Relationship
23. ☐ Anger
24. ☐ Spiritual/religious abuse
25. ☐ Food Issues
26. ☐ Sexual Concerns
27. ☐ Other _____

Dependents/Children

Full name: _____Date of birth: _____Gender: _____

Ethnicity: _____Relationship to you _____

Education: _____ Ability (if any) _____

If a child, who does the child currently live with? _____

Full name: _____Date of birth: _____Gender: _____

Ethnicity: _____Relationship to you _____

Education: _____ Ability (if any) _____

If a child, who does the child currently live with? _____

Full name: _____Date of birth: _____Gender: _____

Ethnicity: _____Relationship to you _____

Education: _____ Ability (if any) _____

If a child, who does the child currently live with? _____

Educational/Vocational Information

Last diploma/degree/last grade completed: _____ _Military (if any): _____

Current occupation status: _____

Current job/school location/name: _____

_____

Medical insurance: _____

Do you have any abilities? _____

If yes, please describe: _____

_____

Health/Medical Information

Are you currently being treated by a medical practitioner? ____ Yes ____ No

If yes, for what purpose? _____

_____

_____

Do you have any chronic medical or physical conditions? ____ Yes ____ No

If yes, what are they and how to they impact you? _____

_____

_____

Are you currently being treated by another mental health provider? ____ Yes ____ No

Do you or someone in your family or someone who you are close with ever struggle with alcohol or drug use? _____

_____

Do you or someone in your family or someone who you are close with struggle with mental illness? ____

_____

_____

Do you or someone in your family or someone who you are close with ever struggle with a significant medical illness? _____

_____

_____

Family/Support/Interpersonal Information

Who is in your current family? _____

_____

What was your childhood like (significant events, illness, school issues, or friend/family problems)? ____

_____

_____

_____

What is your marriage/relationship history? _____

_____

_____

Who is in your support system (Friends, family, co-workers, neighbors, professionals, etc.)?_____

_____

_____

Do you have a religious or spiritual affiliation? _____

_____

_____

Other Intake Information

My reason for receiving psychotherapy now is: _____

_____

_____

Presenting problems/barriers/symptoms: _____

_____

_____

_____

When did this start and for how long have you been experiencing this? _____

_____

_____

Your belief as to cause of the problem: _____

_____

_____

How is this impacting your daily life in your occupation, relationships, health, etc.? _____

_____

_____

What prior experience do you have in counseling? What was helpful to you and what was not? _____

_____

_____

Was there a time when things were better for you than now? If so, please describe your experience. ___

_____

_____

Have you used previous coping strategies or skills in the past? If so, what were they? _____

_____

_____

What is going well for you? How would you describe your strengths? _____

_____

_____

Have you had any significant life situations that have made an impact on you or has helped make you who you are today? This could be positive experiences or something that has negatively impacted you.

_____

_____

_____

_____

What else would be helpful for me to know in getting to know you and providing therapy to you? _____

_____

_____

What specifically would you like to accomplish in working with me? _____

_____

_____

By signing, I understand and acknowledge the content you provided above is confidential and is privileged information and will only be used for the purpose in providing informed therapy services.

_____

Client Name(s) DOB Date

_____

Client Signature DOB Date

_____

Parent/Legal Guardian Signature (if under 13) DOB Date

_____

Therapist Signature Date