# Carol Breeding Arvin, M.A.

## Confidential Client Intake Summary

Name________________________________ Date______________________

Address_________________________________City/state/zip____________________________

Cell phone _________________________ OK to leave message? YES NO

Home phone________________________ OK to leave message? YES NO

Work phone________________________ OK to leave message? YES NO

Age:________Date of birth:_________________ SS#__________________________

Employer (or school, if student)_______________________ Occupation________________

Marital/legal status (circle one): Single Partnered Married Separated Divorced Widowed

Others living in home: name, relationship, and age_____________________________________

_______________________________________________________________________________

Parents or guardian, if child________________________________________________________

Who has primary custody, if child___________________________________________________

Emergency contact_________________________Relationship_________Phone______________

Referred by/from_________________________ Physician_______________________________

Brief description of why you're seeking counseling:_____________________________________

_______________________________________________________________________________

Previous counseling history: approximately how many visits with a therapist?

1-4 5-10 11-30 1 year or more 2 years or more

How was previous therapy helpful or not helpful?_____________________________________

_______________________________________________________________________________

Current medications/dosage_________________________________________________________

Previous medications, dosages, dates, reasons discontinued______________________________

_______________________________________________________________________________

**Family History**

Raised by/lived with________________________________________________________
Place(s) raised_____________________________________________________________
Religious background___________________________Cultural background________________

Family issues. Please indicate who and when:

Alcohol abuse______________________
Depression_________________________
Other mental illness________________
Adoption__________________________
Suicide____________________________
Learning problems__________________
Parental violence___________________
Physical abuse_____________________
Rape______________________________
Active combat______________________
Work problems_____________________
Legal problems_____________________

Drug abuse_____________________________
Anxiety or panic_________________________
Disability_______________________________
Foster care_____________________________
Other deaths____________________________
Health problems_________________________
Divorce/Separation_______________________
Sexual abuse____________________________
Imprisonment___________________________
Natural disaster_________________________
Relationship problems_____________________
Financial problems_______________________

Other problems or trauma; other information or more information about above:

## Personal History

Earliest childhood memory or dream_____________________________________________
______________________________________________________________________________

Most recent night dream_____________________________________________________
______________________________________________________________________________

**Developmental and Educational History**

Prenatal, birth, and infancy concerns:___________________________________________

Childhood illnesses:_________________________________________________________

Education history/highest level

completed:_______________________________________________________________

Learning/school problems:___________________________________________________

Comments:

**History of trauma or abuse**

Neglect/Physical abuse/Sexual abuse___________________________________________

______________________________________________________________________________

Rape or assault____________________________________________________________

Accidents/natural disasters/childhood losses_____________________________________

Comments:

**Substance Use**
Alcohol use (how much/how often) past______________________present__________________
Drug use (what/how much/how often) past_____________________present_________________
Alcohol problem?______________________ Drug problem?________________________
Alcohol or drug problem in family?__________________________________________________
Nicotine use (how much/how often) past_______________________present_________________
Caffeine use (how much/how often)____________________________________
Comments:

**Work History**
Current job:___________________________________________________________________
Previous jobs:__________________________________________________________________
Comments:

**Religious/Spiritual History**
Childhood____________________________ Current___________________________________
Comments:

**Marital History**_________________________________________________________________

## Health Status

Describe current health problems/concerns:___________________________________________

_______________________________________________________________________________

Current treatment:________________________________________________________________

_______________________________________________________________________________

History of significant accidents/injuries (body/head) seizures, loss of consciousness, chronic health conditions, or chronic pain:___________________________________________________

_______________________________________________________________________________

Past psychiatric history: dates, physician, diagnosis, outcome_____________________________

_______________________________________________________________________________

Rate your overall health: excellent, good, fair, poor        Do you exercise regularly? Yes/no
If yes, what types of exercise and how often?________________________________________

Sources of help—people, groups, spiritual, etc.______________________________________

**Please check any of the following that apply:**

___Anxiety/worry
___Panic attacks
___Fear
___Restlessness
___Anger
___Frustration
___Confusion
___Shyness
___Feeling inadequate
___Disorganized
___Difficulty making decisions
___Stress
___Loneliness
___Guilt
___Shame
___General unhappiness
___Depression
___Grief
___Crying spells
___Boredom
___Mood swings
___Suicidal thoughts
___Thoughts of hurting others
___Unwanted thoughts/rituals
___Problems at work
___Relationship problems
___Concern about sexual identity/preference
___Concern about sexual function
___Financial concerns
___Memory lapses, blank periods
___Unable to concentrate
___Headaches
___Aches or pains
___Abdominal problems
___Fatigue
___Low energy
___Nightmares
___Unwanted memories or images
___Cutting, burning or other self-harm
___Sudden impulses
___Difficulty coping with daily demands
___Difficulty trusting other
___Secrets I'm afraid to tell
___Physical problems or pain
___Disturbing fears
___Communication difficulties
___Inability to stop doing certain things
___Hearing voices/things others don't hear
___Depending too much on others
___Peculiar or wierd experiences
___Feeling different from others
___Alcohol or drug abuse problem
___Restrict food
___Binge/purge food
___Use laxatives/exercise to control weight

Recent changes in sleep patterns (#hrs more/less than usual):__________
Recent weight change (how many lbs. +/-):___________

What I hope from therapy is:_______________________________________________________

What I fear about therapy is:_______________________________________________________

What I most want my therapist to do is:______________________________________________

One question I would like you to answer is:__________________________________________

Something else I would like you to know is:__________________________________________

Personal strengths_________________________________________________________________

and challenges____________________________________________________________________

Thank you for taking the time to fill this out!