Jason M. Adams, LPC, NCC

Licensed Professional Counselor • National Certified Counselor

www.JasonAdamsOnline.com

CLIENT INTAKE FORM

CLIENT INFORMATION

Last Name	First	Middle	Gender ☐ M ☐ F

Date of Birth	Age	Email address

Street Address	City	State	Zip Code

Mailing Address (if different from above)	City	State	Zip Code

Home Phone	Cell Phone	Work Phone

Referred by:
☐ Physician ☐ Clergy ☐ Family ☐ Friend ☐Internet ☐ Other ___________________________

PREFERRED METHOD OF CONTACT

Please indicate your preferred method(s) of contact in the event you need to be reached regarding appointment scheduling or other issues: ☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ Email ☐ Postal Mail

EMERGENCY CONTACT

Name	Relationship	Home phone	Other phone

MARITAL HISTORY

☐ Single / never married	☐ Separated (Date: ___________)	☐ Widowed / Widower (Date: ___________)
☐ Married (Date: ___________)	☐ Divorced (Date: ___________)	☐ Living with someone (How long? _____________)

Do you have children? ☐ Yes ☐ No

CURRENT STATUS

Please check any of the following that describe how you have been feeling recently (check all that apply):

☐ Aggressive ☐ Agitated ☐ Angry ☐ Anxious ☐ Ashamed ☐ Confused ☐ Depressed ☐ Extreme ups / downs

☐ Frightened ☐ Guilty ☐ Helpless ☐ Hopeless ☐ Irritable ☐ Jealous ☐ Resentful ☐ Sad ☐ Stressed

☐ Suspicious ☐ Tearful ☐ Worried ☐ Worthless ☐ Other: ______________________________

Please check any current symptoms (check all that apply):

☐ Concentration / focus problems ☐ Decreased energy ☐ Excessive worry ☐ Hyperactivity ☐ Impulsivity

☐ Memory difficulties / forgetfulness ☐ Panic attacks ☐ Relational conflicts ☐ Self-injurious behavior ☐ Weight changes

What activities or hobbies do you participate in?	Describe your current working environment

Do you participate in regular exercise?

☐ Yes ☐ No Describe: ______________________________

Have you had any change in sleeping habits?

☐ Yes ☐ No Describe: ______________________________

Have you had any change in eating habits?

☐ Yes ☐ No Describe: ______________________________

Have you ever considered suicide, recently or in the past?

☐ Yes ☐ No Describe, including dates: ______________________________

Have you ever attempted suicide?

☐ Yes ☐ No Describe, including dates: ______________________________

Have you ever considered homicide, recently or in the past?

☐ Yes ☐ No Describe, including dates: ______________________________

Please check any of the following that apply to you

☐ I sometimes hear voices, even though no one nearby is talking to me.
☐ I sometimes feel that forces outside of me control me.
☐ I sometimes feel that other people control my thoughts.
☐ I sometimes have the same thought over and over and cannot control it.
☐ I sometimes feel that someone is out to hurt me or do something against me.
☐ I am sometimes unable to control my behavior. Please explain: ______________________________
☐ None of the above

What makes you happy?	What scares you?
What are your goals?	Why have you chosen to see a counselor/therapist?

Is there any other information that you would like to share that is not covered on this form?