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Chrysalis Behavioral Therapy and Counseling

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Client Intake Form

Name of Client **Name of Legal Guardian (if client is a minor)**		**Today's Date**
Client Address **Address of Legal Guardian if different from Client**		**Client Date of Birth** Age
City State Zip	**Preferred Phone Number:** **Okay to leave Message?** Y N **Okay to text?** Y N	**Client Marital Status:** *(circle)* Single Married Divorced Widowed Separated
Email Address? **Okay to use for communication with you?**	**Alternate Phone:** Cell Home Work **Okay to leave Message?** Y N **Okay to text?** Y N	***If Client is a Minor:*** **Parent's Marital Status:** (circle) Single Married Divorced Widowed Separated
What brought you to counseling today?		

Referral Information

How did you hear about this practice (who referred you)?

Are you currently involved with a pending or active legal suit (Probation, CPS, etc.)? YES NO

If YES, who?

If YES, please complete the Legal and Court Status Information Form Attached

Are you currently seeking counseling services elsewhere? YES NO

Employment Information

Employer (if unemployed, list most recent employer, If Student, provide school name & grade)

Employment Status: Student Unemployed Full-Time Part-Time

Volunteer Retired

Family

Name	Relation	Age	Living (Y/N)	In Home? (Y/N)	Brief description of any mental or substance use history?

Please circle the symptoms you have experienced in the last month (cont'd on next page)

Crying spells	Fast heartbeat	Money problems
Unable to have fun	Always worried	Relationship concerns
Feelings easily hurt	Frequent sweating	Work difficulties
Lacking in confidence	Dizziness	Sexual problems
Constipation	Shaky hands	Can't hold a job
Feeling grouchy	Stomach trouble	Excessive drinking
Always tired	Nightmares	Excessive medication use
Poor appetite	Feeling tense	Excessive drug use
Depressed	Cold feet and hands	Problems with children
Trouble sleeping	Feeling panicky	Problems with parents

Feeling lonely Loss of weight Not enjoying things Suicidal thoughts Loss of sexual interest No one understands me Worried about health Can't concentrate Can't "get going" Feeling angry Don't like being alone Lack of energy	Diarrhea Shy with people Muscle twitching Nausea or vomiting Can't make decisions Can't make friends Headaches Fainting spells Unable to relax Feeling fearful Overly sensitive Anxious inside Weight gain	Poor physical health Fighting and quarreling Dislike my body Full of energy Overly ambitious Easily excited Quick tempered impatient with people Binge eating Very restless Feel like hurting someone Feel like smashing things Excessive overeating Thoughts of hurting myself Other: ______

Medical Information

Overall Physical health	**Excellent Very Good Good Fair Poor Bad**		
Date of Last Physical		**Currently being seen by a medical doctor?**	**YES NO**
Have you ever experienced a head injury, concussion or loss of consciousness?		**If YES, how many times?**	

List your current medical prescriptions including vitamins, supplements & hormone therapies

Please inform your counselor if this list changes over time. Use the back of this page as needed

Name	Reason	Dosage/Day

Have you taken any anti-depressant or anxiety drugs in the past? YES NO			
Have you ever been hospitalized for mental health or substance related issues? YES NO If YES, please provide the following			
Place	Reason	Dates	Discharge Status *(ex: left against medical advice, completed program, ran out of insurance)*

I have made every effort possible to provide the most current and accurate information on this form and understand I am responsible for informing my counselor of any updates.

Client

Signature____

Date_________