Client Intake Form

Name: ____ Case Number: _______________

A. PRESENTING CONCERNS

Briefly describe the concern that brings you to PILLAR:

Approximately how long has this concern been bothering you?

Please ***CHECK ALL ITEMS THAT CONCERN YOU****:*

- ☐ 1. School concerns
- ☐ 2. Addictions
- ☐ 3. ADHD/learning problems
- ☐ 4. Adjustment to new situation
- ☐ 5. Alcohol or drug concerns
- ☐ 6. Anxiety, fear, nervousness
- ☐ 7. Career/job concerns
- ☐ 8. Repetitive behavior
- ☐ 9. Concentration difficulties
- ☐ 10. Concern about other’s
- ☐ 11. Cutting or self-injury
- ☐ 12. Depression, sadness
- ☐ 13. Discrimination
- ☐ 14. Eating Concerns/body image
- ☐ 15. Emotional abuse
- ☐ 16. Episodes of unusual behavior
- ☐ 17. Family problems
- ☐ 18. Feeling doomed or helpless
- ☐ 19. Financial concerns
- ☐ 20. Harassment
- ☐ 21. Identity/sense of self
- ☐ 22. Impulse control
- ☐ 23. Intimate concerns
- ☐ 24. Interpersonal concerns
- ☐ 25. Legal concerns
- ☐ 26. Loneliness
- ☐ 27. Loss, grief, death
- ☐ 28. Self-esteem
- ☐ 29 Medical or health concerns
- ☐ 30 Mood swings
- ☐ 31. Obsessive thoughts
- ☐ 32. Panic attacks
- ☐ 33. Paranoia
- ☐ 34. Phobias (fear)
- ☐ 35. Physical abuse or assault
- ☐ 36. Relationship concerns
- ☐ 37. Racing thoughts
- ☐ 38. Risky behavior
- ☐ 39. Sexual abuse or sexual assault
- ☐ 40. Sexuality concerns
- ☐ 41. Sleep difficulties
- ☐ 42. Spiritual or religious concerns
- ☐ 43. Stress or tension
- ☐ 44. Thinking about suicide

Low Intensity: 1------2------3------4------5 :High Intensity			
Please indicate by number, which of the above concerns are most important to you (e.g. 11, 28, 12)			
		Rate of intensity of client’s concern	Current level of distress for concern
1st Most Important:		☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
2nd Most important:		☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
3rd Most important:		☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

What factor(s)/situation make your concerns worse?

What factor(s)/situation lessens your concerns?

B. LEVEL OF IMPACT

How much do your concerns interfere with your:

Emotional Well-Being:	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
Social Relationships/Social Activities:	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
Daily Routine:	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

C. MENTAL HEALTH HISTORY

Have you received counseling or psychotherapy in the past? If yes, please provide date and year(s)	☐Yes ☐No
Have you received counseling or psychotherapy for your current concern? If yes, what is/was the name of the therapist and/or agency?:	☐Yes ☐No
Are you a returning client to PILLAR? If yes, when and who was your counselor	☐Yes ☐No
Are you currently receiving psychiatric services, professional counseling, or psychotherapy elsewhere?	☐Yes ☐No
Have you been proscribed psychiatric medication in the PAST?	☐Yes ☐No
Are you CURRENTLY taking prescribed psychiatric medication, antidepressants, or others? If yes, list medications:	☐Yes ☐No
Have you been hospitalized for psychiatric reasons?	☐Yes ☐No
Have you ever had thoughts of harming yourself?	☐Yes ☐No
Have you purposely injured yourself without suicidal intent? (e.g., cutting, hitting, burning, etc.)	☐Yes ☐No

In the last 15 days, have you had suicidal thoughts? ☐ Yes (specify below) ☐ No

If YES, answer the following questions:

FREQUENCY:	☐Rarely	☐Sometimes	☐Frequently	☐ Always
DURATION:	☐Seconds	☐Minutes	☐Hours	☐Constant
INTENSITY:	☐Brief and fleeting	☐Focused deliberation	☐ Intense rumination	

Have you seriously considered attempting suicide in the past? ☐ Yes (specify below) ☐ No

If YES, please describe: (e.g., age, issues, what happened)

Have you made a suicide attempt? ☐ Yes (specify below) ☐ No

If YES, please describe when and the nature of the attempt:

Have you seriously considered harming another person? ☐ Yes (specify below) ☐ No

Did you receive help? ☐ Yes (specify below) ☐ No

If YES, please describe when and the nature of the help you received:

Have you ever intentionally physically harmed someone? ☐ Yes (specify below) ☐ No

If YES, describe when, who, and how:

Do you CURRENTLY have thoughts of harming another person? ☐ Yes (specify below) ☐ No

If YES, please describe:

D: SUBSTANCE ABUSE

Do you regularly drink alcohol? ☐ Yes (specify below) ☐ No

In a typical month, how often do you have 4 OR MORE DRINKS in a 24-hour period?
☐ Never ☐ Rarely ☐ Monthly ☐ Weekly ☐ Daily or Almost Daily

Do you consider your alcohol consumption a problem? ☐ Yes ☐ No ☐ Not Applicable

Have you used any drug in the past 30 days that was not prescribed by a doctor? (e.g., marijuana, meth, cocaine, diet pills, ecstasy, Xanax, valium, Ritalin, Adderall, LSD, acid, mushrooms, heroin, codeine, or other) ☐ Yes (specify below) ☐ No
If YES, indicate which substance(s) and when:

How often do you engage in recreational drug use?
☐ Never ☐ Rarely ☐ Monthly ☐ Weekly ☐ Daily or Almost Daily

Do you consider your drug use a problem? ☐ Yes ☐ No ☐ Not Applicable

Have you ever received treatment for alcohol or drug use? ☐ Yes (specify below) ☐ No
If YES, indicate when, where, and substance(s)

Was it helpful?☐ Yes ☐ No

What is your typical DAILY NICOTINE intake?
☐Never or infrequently ☐Less than 5 cigarettes ☐5-20 cigarettes ☐More than 20 cigarettes
☐Other (e.g., nicotine patch):____

E: HEALTH AND SOCIAL ISSUES

When was your last physical exam? Month_______________ Year_______________

How is your physical health at present?☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good Excellent

Have you had any serious accidents, injuries, or illnesses? ☐ Yes (specify below) ☐ No
If YES, please describe:

Are you presently taking any medications? (e.g., prescribed medications, over-the-counter drugs, alternative remedies, etc.) ☐ Yes (specify below) ☐ No
If YES, please list:

Please list any PERSISTENT PHYSICAL SYMPTOMS or health concerns: (e.g., chronic pain, headaches, hypertension, diabetes, etc.)

Are you having any problem with your sleep habits?
☐ No problems ☐ Sleeping too much ☐ Sleeping too little ☐ Poor quality of sleep ☐ Disturbing dreams
☐ Other (please describe):

How many times per week do you exercise? ☐ One or less ☐ Two to Four ☐ Five or more
For about how long each time?

Are you having difficulty with appetite or eating habits?
☐ No difficulty ☐ Eating less ☐ Eating more ☐ Binging ☐ Restricting ☐ Significant weight change ☐ Other:____
Please describe the nature of your eating habits or weight change: (e.g., frequency of eating patterns, how much weight lost and time frame, etc
____
____

Do you have any problems or worries about sexual functioning? (check all that apply)
□ No concerns □ Lack of desire □ Performance problem □ Sexual impulsiveness
□ Difficulty maintaining arousal □Worried about sexually transmitted disease
□Other (please describe):____

Besides family members, approximately how many people can you really count on right now for friendship and emotional support?____

Approximately how many significant intimate relationships (lasting 6 months or more) have you been involved in the last couple of years?____

Are you in a significant intimate relationship now? □ Yes □ No

F: FAMILY & CULTURAL BACKGROUND

Please list the members of your family.

Family Member	Age	Occupation/School

In general, how happy or adjusted were you growing up?
□ Not at all □ Unsatisfactory □ Average □ Substantially □ Completely

Does your family speak a language other than English at home?
□No □ Very little □ Sometimes □ Moderately □ Strongly
If YES, what language(s):

How much conflict in values do you currently experience with your parents?
□ Very little or none □ Some □ Moderate □ Strong □ Extreme

Religious preference: Are you currently active in your religion? □ Yes □ No

How much is your immediate family a source of emotional support for you?
□ Not at all □ A little □ Somewhat □ Substantial □Very strong

Have you personally experienced LEGAL PROBLEMS? □ Yes □ No
If YES, please describe:

Did you experience LEARNING PROBLEMS in elementary or high school?
□ None □ A little □ Some □ Substantial □ A lot, constant struggle

Do you have children? □ Yes □ No
If YES, please list age and gender of children:

Please check any past, present, or impending special problems in your family. Please specify the problem, family member(s), and time of occurrence:

☐ DIVORCE/MARITAL PROBLEMS
☐ SERIOUS PHYSICAL ILLNESS, DISABILITY, OR DEATH
☐ ALCOHOL/SUBSTANCE ABUSE PROBLEMS☐d)PSYCHIATRIC ILLNESS/EMOTIONAL PROBLEMS
☐FINANCIAL PROBLEMS/UNEMPLOYMENT
☐LEGAL PROBLEMS
☐OTHER: