Dr. Shannon Lilja DBH LPC LMHC CDP CADC-II

CLIENT INTAKE

Today's date _____

Client's Name: _____ Birthdate: _____ Age: _____

Address: _____ Home Telephone: _____

_____ Alternate Phone: _____

Specific Culture(s) You Embrace? _____

Marital Status: _____ # Marriages: _____ # Years Together: _____ # Years Single: _____

Partner's first name and occupation: _____

Children: sex/age now _____ sex/age now _____ sex/.age now _____ sex/age now _____

Unsuccessful or terminated pregnancies? _____

Your Family of Origin:

Were you adopted? _____ Were you in foster care? _____

Biological Siblings: sex/age now _____ sex/age now _____ sex/age now _____ sex/age now _____

Step/Half Siblings: sex/age now _____ sex/age now _____ sex/age now _____ sex/age now _____

Are your parents living? Mother _____ Father: _____

Briefly describe your mother: _____

Briefly describe your father: _____

Briefly describe your childhood homelife: _____

Your highest school grade completed, technical training, or degree earned: _____

Any special licenses or certifications earned: _____

Did you graduate with your class? _____ Diploma? _____ GED _____ Exit school before graduation _____

Military History? _____

Discharge Type: _____

Health History:

Substance Use. Please fill in the dates/amounts of average use over past month's time.

Alcohol		Methamphetamine		Percocet/Oxycodone	
Caffeine		Cocaine/Crack		Methadone	
Marijuana		LSD/Hallucinogens		Morphine	
Sleeping Aid		Benzodiaz/Xanax		Hydrocodone/Vicodin	
Tobacco/Smk		Other Stimulant:		Heroin	
Tobacco/Chw		Other Relaxant:		Other Pain Meds	

Are you concerned about your drug or alcohol use? _____

Have you ever been enrolled in a substance abuse program (when/where): _____

Have you ever been hospitalized for psychological reasons? _____

Have you ever harmed yourself (ie cutting): Please explain _____

Have you ever attempted suicide? (details) _____ _____

Do you currently (in past week) feel like harming yourself or attempting suicide? _____

Have you ever had homicidal thoughts? Please explain _____

Describe your personal experience to domestic violence: _____

Do you have any general health issues or concerns? _____

Describe your sleeping patterns: _____

Describe your exercising/physical activity patterns: _____

Describe your eating habits: _____ _____

Are you comfortable with your weight or appearance? _____

Check ("X") all that have applied during your lifetime. Please a "P" next to current conditions:

_____ aggression
_____ excessive anger
_____ low self-esteem
_____ drug/alcohol use
_____ frequent family moves
_____ preoccupation w/sex
_____ sexually active < age 13
_____ depression
_____ delinquency
_____ attention deficit
_____ anxiety attacks
_____ thyroid (hypo/hyper)
_____ head injury
_____ physical abuse
_____ bed-wetting
_____ self abusive behaviors
_____ persistent fears; anxiety
_____ nail biting
_____ sleep walking
_____ sleep difficulties
_____ excessive guilt or shame
_____ excessive shyness
_____ difficulty w/social relationships
_____ difficulty w/romantic partner
_____ migraines
_____ learning disabilities
_____ diabetes
_____ seizures
_____ emotional abuse
_____ loss of loved one
_____ eating disorder
_____ underweight
_____ overweight
_____ frequent illness
_____ suicidal thoughts
_____ suicidal attempts
_____ late thumb sucking
_____ unhappy childhood
_____ infertility
_____ sexual difficulties
_____ allergies
_____ ear/eye difficulties
_____ sexual abuse
_____ night terrors
_____ hyper-activity

Current Occupation: _____

Describe your present job (stressful, enjoyable): _____

Describe present social involvement, friendship network, organizational involvements:

_____

Describe what is causing you the most concern, or stress, at this time: _____

_____

What do you enjoy doing most? _____

What are your greatest accomplishments? _____

What are your strengths – the personal 'internal' resources that you use to cope with life stressors, that you and/or others notice or appreciate about you? _____

_____

_____

Have you ever received previous psychological treatment? If so, by whom? _____

_____

Have you been diagnosed with a mental disorder? _____

What brings you to counseling at this time? _____

_____

In the case of an emergency, who should be contacted?

_____

Client Name: _____ Client Signature: _____

Date: _____

Thank you for completing this form. Please write any additional comments below or on the reverse side.