



Sandalwood
Counseling LLC

Dr. Shannon Lilja DBH LPC LMHC CDP CAD-C-II

CLIENT INTAKE

Today's date _____

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

Address: _____ Home Telephone: _____

_____ Alternate Phone: _____

Specific Culture(s) You Embrace? _____

Living with: Self ____ Roommate(s) ____ Partner ____ Spouse ____ Children ____ Parents ____

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? _____

Health History:

Substance Use. Please fill in the dates/amounts of use.

Alcohol		Methamphetamine		Percocet/Oxycodone	
Caffeine		Cocaine/Crack		Methadone	
Nicotine		LSD/Hallucinogens		Morphine	
Sleeping Aid		Benzodiaz/Xanax		Hydrocodone/Vicodin	
Marijuana		Other Stimulant:		Heroin	
		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:

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