Seeds of Change Therapy
2501 Parkview Drive, Suite 305
Fort Worth, Texas 76102

Client Intake Packet

Confidential Client Information

Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information.

Date of Initial Appointment_____

Name_____

Date of Birth_____Age _____

Address_____

City_____State_____Zip_____

Home Phone_____ OK to leave message here? Yes___ No___ Initial___

Work Phone_____ OK to leave message here? Yes___ No___ Initial___

Cell Phone_____OK to leave message here? Yes___ No___ Initial___

Email _____

May I put you on my email list for newsletters, classes, or workshops? Yes___ No___ Initial___

May I text you? Yes _____ No _____ Initial _____

*Please note that email correspondence or texting is not considered to be a confidential means of communication.

If client is an adult, please complete the following information:

Occupation _____Education: Grades completed _____

Degree(s) earned _____ Employer _____

Position _____ How long in present job? _____

Confidential Client Information *continued*

Marital Status _____

Spouse / Significant Other / Partner's Name_____

Is your spouse / partner supportive of you seeking counseling? _____

Date of Marriage _____ Married before? Yes _____ No _____ How many times? _____

How did the previous marriage(s) end and when? _____

_____

_____

Do you have children or step-children? _____

Names and ages _____

_____

_____

_____

If client is a child, please complete the following information:

Name of Parent(s) or Guardian(s)_____Phone _____

Name of Noncustodial/Other Parent _____Phone _____

Names of siblings _____

_____

Child's relationship with Other Parent/Guardian _____

Is the Other Parent/Guardian aware of and supportive of counseling? _____

Child's School and Grade Level _____

Child's School Performance/Behavior _____

Confidential Client Information *continued*

Emergency Information:

In case of emergency, contact:

Name _____ Relationship _____ Phone _____

Referral Source:

How did you hear about me? _____

On the internet? _____ Website? _____ Facebook/Twitter?_____

An individual? _____

Was there a specific referral? Yes _____ No _____ Name _____

Address: _____

Phone: _____

Is it OK for me to contact that person to thank them for their referral? Yes _____ No _____

Current Situation:

What made you start coming to therapy at this time?

What do you see as the single biggest problem?

Confidential Client Information *continued*

What issues, situations, or other events do you think have contributed to this difficulty?

How do you manage stress? (hobbies, exercise, interests, social relationships}

If therapy worked for you, what would be different?

Health History:

Your Doctor:_____Phone: _____

Date of last physical exam:_____Reason: _____

List any prescriptions and over-the-counter medications that you presently use for any physical or medical condition: _____

_____

_____

How would you rate your current physical health? _____

Please list any specific health problems you are currently experiencing: _____

_____

How would you rate your current sleeping habits? _____

Confidential Client Information *continued*

Please list any current sleep problems you are currently experiencing: _____

_____

How many times per week do you generally exercise? _____

What types of exercise do you participate in? _____

Are you currently experiencing any difficulties with your appetite or eating patterns? _____

If so, what are they? _____

Are you currently experiencing any chronic pain? _____

If so, please describe it. _____

Please list any major health problems, allergies, significant injuries, and history of head injury or chronic illnesses: _____

_____

Is there any physical illness in your family that keeps repeating (heart disease, cancer, diabetes, etc.)? If so, what? _____

Counseling History:

Have you been in counseling before? If yes, with whom? _____

What was the primary problem for which you were in counseling? _____

_____

When was the counseling? _____For how long? _____

What was the outcome? _____

Have you ever been in a hospital or residential program for emotional or behavioral problems?

If so, when _____, where _____, outcome _____

_____

Confidential Client Information *continued*

Have you ever taken medication(s) for emotional or behavioral problems? _____

What are the medications? _____

Which physician is prescribing these medications? _____

Are you currently experiencing overwhelming sadness, grief or depression? _____

If yes, please describe

_____

If yes, for approximately how long? _____

Are you currently experiencing anxiety, panic attacks or have any phobias? _____

If yes, please describe

_____

If yes, for approximately how long? _____

Is there a history of emotional or mental illness in your family? _____

If yes, what types of problems and which family members suffered from these problems? _____

_____

Is there a history of domestic violence in your family? _____

If yes, please describe _____

Substance Abuse:

Have you ever received treatment for substance abuse? _____

If yes, when and where _____

Confidential Client Information *continued*

Please check the substances you have used, past and present:

	Past	Present		Past	Present
Alcohol	___	___	PCP	___	___
Marijuana	___	___	Cocaine	___	___
Heroin	___	___	LSD	___	___
Amphetamines	___	___	Opiates	___	___
Ecstasy	___	___	Sedatives	___	___
Meth	___	___	Designer Drugs	___	___
Barbiturates	___	___	Others	___	___

Does anyone else in the family use alcohol or drugs? If yes, who and what do they use? _____

_____

Legal History:

Are you currently, or have you ever been, involved with the legal system? _____

_____

If yes, for what reasons? (truancy, traffic tickets, juvenile offenses, etc.) _____

_____

Do you anticipate being involved in further legal action in the future? (criminal, divorce, custody, civil, etc.) If yes, please explain _____

_____

_____

Confidential Client Information *continued*

Family:

How would you rate your social life?

Very Negative 1 2 3 4 5 6 7 8 9 10 Very Positive

How would you rate your current relationship with your spouse or significant other?

Very Negative 1 2 3 4 5 6 7 8 9 10 Very Positive

How would you rate your current relationship(s) with your children, if any?

Very Negative 1 2 3 4 5 6 7 8 9 10 Very Positive

Religious Information – Is religion and/or spirituality important to you or other family members? If so, please describe: _____

_____

_____

What losses, changes, or crises have made a big impact on your life (parent's divorce, arrests, graduation, moves, death in family, etc.)? What age were you when these changes occurred?

_____

_____

_____

What do you consider to be some of your personal strengths and resources? _____

_____

_____

_____

_____

Confidential Client Information *continued*

What do you consider to be some of your family's strength and resources? _____

_____

_____

_____

_____

Is there anything else about your lifestyle, including the family, that would be helpful for me to know? _____

_____

_____

_____

_____