

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

**Client Intake Packet**

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**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?

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**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 \_\_\_\_\_

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**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? \_\_\_\_\_

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

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