Laguna Beach Counseling
333 Third Street, Suite 6, Laguna Beach CA 92651 | www.lagunabeachcounseling.com | 949.357.3587

CLIENT INTAKE

Information provided on this form is protected as confidential information.

PERSONAL INFORMATION

Name:_____ Date: _____

DOB: _____ Age: _____ Ethnicity: _____

Gender: □ Female □ Male □ Transgender □ Intersex □ Other □ Prefer not to say

Preferred Pronouns (ex: he/his, her/hers): _____

Parent/Legal Guardian (if under 18): _____

Address: _____

Cell Phone: _____ May we leave a message? □ YES □ NO

Home/Work/Other Phone: _____ May we leave a message? □ YES □ NO

Email: _____ May we leave a message? □ YES □ NO

**Please note: Email correspondence is not considered to be a confidential medium of communication.*

Relationship Status: □ Never Married □ Domestic Partnership □ Married □ Separated

□ Divorced □ Widowed □ Other: _____

Please list any prescribed medications or vitamins, herbs, supplements you are currently taking:

_____

_____

Have you previously received any type of mental health services/counseling?

Individual: □ YES □ NO □ Currently Receiving Name of Clinician: _____

Couples: □ YES □ NO □ Currently Receiving Name of Clinician: _____

Family: □ YES □ NO □ Currently Receiving Name of Clinician: _____

Have you previously received a mental health diagnosis? □ YES □ NO

If yes, please describe and list when diagnosis was received: _____

Referred By (if any): _____

CHILDREN INFORMATION

Name:_____ Age: _____

Name:_____ Age: _____

Name:_____ Age: _____

Name:_____ Age: _____

GENERAL HEALTH INFORMATION

How would you rate your current ***physical*** health?

□ Poor □ Unsatisfactory □ Satisfactory □ Good □ Very good

Please list any specific problems you are currently experiencing: _____

How would you rate your current ***mental*** health?

□ Poor □ Unsatisfactory □ Satisfactory □ Good □ Very good

Please list any specific problems you are currently experiencing: _____

How would you rate your current ***sexual*** health?

□ Poor □ Unsatisfactory □ Satisfactory □ Good □ Very good

Please list any specific problems you are currently experiencing: _____

How would you rate your current ***spiritual*** health?

□ Poor □ Unsatisfactory □ Satisfactory □ Good □ Very good

Please list any specific problems you are currently experiencing: _____

How would you rate your current ***financial*** health?

□ Poor □ Unsatisfactory □ Satisfactory □ Good □ Very good

Please list any specific problems you are currently experiencing: _____

How would you rate your current sleeping habits?

□ Poor □ Unsatisfactory □ Satisfactory □ Good □ Very good

Please list any specific problems you are currently experiencing: _____

How many times per week do you generally exercise? _____

What types of exercise do you participate in? _____

Please list any difficulties you experience with your appetite or eating problems: _____

Are you currently experiencing overwhelming sadness, grief, or depression? □ YES □ NO

If yes, please describe and when did you begin experiencing? _____

Are you currently experiencing anxiety, panics attacks or have any phobias? □ YES □ NO

If yes, please describe and when did you begin experiencing? _____

Are you currently experiencing any chronic pain? □ YES □ NO

If yes, please describe: _____

How often do you consume alcoholic beverages? □ Daily □ Weekly □ Monthly □ Infrequently □ Never

How often do you engage in recreational drug use? □ Daily □ Weekly □ Monthly □ Infrequently □ Never

What significant life changes or stressful events have you experienced recently? _____

_____

RELATIONSHIP INFORMATION

Are you currently in a romantic relationship? □ YES □ NO If yes, length of time: _____

If yes, on a scale of 1-10 (with 1 poor and 10 exceptional), how would you rate your relationship? ____

Have either of you threatened to separate or divorce (if married) as a result of the current relationship concerns? □ YES □ NO If yes, who? □ ME □ PARTNER □ BOTH OF US

Do you misuse/overuse alcohol or drugs? □ YES □ NO Does your partner? □ YES □ NO

Have you ever struck, physically restrained, used violence against or injured your partner? □ YES □ NO

Has your partner ever struck, physically restrained, used violence against or injured you? □ YES □ NO

If yes for either, who, how often and what happened? _____

_____

Check each of the following symptoms you are currently or have experienced within the past six (6) months:

□ Affection	□ Holding the other back	□ Sexual Issues	□ Agreeing on Chores	□ Housing
□ Closeness	□ Showing Appreciation	□ Guilt/Shame	□ Solving Problems Together	□ In-laws
□ Finances	□ Partner's Cleanliness	□ Common Goals	□ Common Interests	□ Parenting
□ Relatives	□ Trusting Each Other	□ Communication	□ Use of Time	□ Jealousy
□ Friendships	□ Physical Fighting	□ Verbal Fighting	□ Having Fun Together	□ Recreation
□ Infidelity	□ Other _____			

Which of these symptoms do you wish to address in counseling at this time? Why now? _____

_____

FAMILY MENTAL HEALTH HISTORY

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (e.g. father, grandmother, uncle, etc.)

Alcohol/Substance Abuse yes / no_____

Anxiety yes / no _____

Depression yes / no _____

Sexual Abuse yes/no _____

Domestic Violence yes / no _____

Eating Disorders yes / no _____

Obesity yes / no _____

Obsessive Compulsive Behavior yes / no _____

Schizophrenia yes / no _____

Suicide Attempts yes / no _____

ADDITIONAL INFORMATION:

Are you currently employed? □ YES □ NO

If yes, what is your current employment situation? _____

Do you enjoy your work? Is there anything stressful about your current work? _____

_____

Do you consider yourself to be spiritual or religious? □ YES □ NO

If yes, describe your faith or belief: _____

_____

What would you like to accomplish out of your time in therapy? _____

_____

_____