east counseling services, inc

Intake Information Form

Please complete the following information for the person who will be receiving counseling.
Complete <u>separate forms</u> for <u>each person</u> who will be receiving counseling.

First Name of **CLIENT**:		MI:	Last Name:	
☐ Male ☐ Female	Race:	Date of Birth:	Age:	SSN of CLIENT:
Mother's Name: Age:		Father's Name: Age:		
Address **OF CLIENT**:			Apt/Lot/Unit:	
City:		State:	Zip: -	
Home Phone: ( )		Work # for _____:	Work # for _____:	
Cell Phone for _____:		Email addresses:		
Employer:	Occupation/Title:		How Long Employed There? _____ Years	
Military Background:	Church Background:	MEDICAL CONDITIONS: 1. 2.	3. 4.	
List Medications: 1. 2. 3.	4. 5. 6.	7. 8. 9.	Name of MD or Psychiatrist:	

Education Completed: Grade:_____ Current School: _____ ☐ Full-Time Student ☐ Part-Time Student
☐ Associate Degree ☐ Bachelor's Degree ☐ Master's Degree ☐ Doctorate Degree

Current Marital Status: ☐ Never Married ☐ Engaged ☐ Separated ☐ Divorced ☐ Widowed ☐ Married # Times Married: _____

No. Years of Current Marriage/Relationship: _____ Years | Name of Present Spouse/Partner:

Spouse's Employer: | Spouse Occupation/Title:

NAMES OF **CHILDREN**	AGE	NAMES OF **BROTHERS/SISTERS**	AGE
1_____	_____	1_____	_____
2_____	_____	2_____	_____
3_____	_____	3_____	_____
4_____	_____	4_____	_____
5_____	_____	5_____	_____

Has Client Received Counseling Before? ___yes __no | If yes, when? With whom?

Please check symptoms/concerns the client is experiencing:

☐ Anxiety/Worry	☐ Panic Attacks	☐ Depression/Sadness	☐ Irritability	☐ Anger Outbursts	☐ Difficulty Concentrating
☐ Hyperactivity	☐ Sleeping Too Much	☐ Difficulty Sleeping	☐ Overeating	☐ Under-eating	☐ Work Problems
☐ School Problems	☐ Recent Trauma	☐ Grief/Death/Loss	☐ Sexual Problems	☐ Marital Problems	☐ Parenting Difficulties
☐ Suicidal Thoughts	☐ Health Problems	☐ Adoption Issues	☐ Legal Problems	☐ Alcohol Abuse	☐ Drug Abuse
☐ Relationship Problems	☐ Abuse Issues	☐ Domestic Violence	☐ Divorce Concerns	☐ Other: _____	

How did you find out about ECS? ☐ Friend ☐ Insurance Company ☐ Doctor ☐ Talking Phone Book ☐ Sign ☐ Church ☐ Other:

Signature of Client: **Date:**

Signature of Parent/Guardian if Client is a Minor: **Date:**