Client Intake Checklist

Dear Client: To serve you better and help us make sure we will cover any areas of concern you may have, please circle your answer to each question below. Thank you for your cooperation.

Name: ____ Date: _________________________

Address: ____

Age/Birth Date: _____________________________________

1) Do you have any current or history of medical conditions/illnesses? Yes No

   If yes, explain ____

2) Are you on any current medications/treatment? Yes No

   If yes, medication/treatment ____

   Physician name/phone ____

3) Are you having difficulty sleeping? Yes No

4) Have you/others been concerned about your alcohol or drug use? Yes No

5) Do any family members have alcohol or drug problems? Yes No

6) Do you starve yourself or make yourself throw up? Yes No

7) Do you have sexual concerns? Yes No

8) Do you have thoughts about hurting yourself? Yes No

9) Do you have any thoughts about hurting others? Yes No

10) Do you feel you are in danger of being hurt? Yes No

11) Have you moved in the last two years? Yes No

12) Do you find it hard to talk about personal problems with other people? Yes No

13) Do you have problems in your relationships with other people? Yes No

14) Do you prefer not to participate in community or social activities? Yes No

15) Have you changed jobs/schools in the last two years? Yes No

16) Do you hate going to work/school? Yes No

17) Do you have a legal problem? Yes No

18) Are your experiencing financial problems? Yes No

19) Have you lost hope that your problem can be resolved? Yes No

20) Have you lost motivation to work on your problem? Yes No