Mary Quirk, M.A., L.P.C., N.C.C.
45 County Road 537 West • Colts Neck, N.J. 07722 (732) 303-7999

CLIENT INTAKE FORM

Date _____ Name _____
Address _____
City _____ State _____ Zip Code _____
Home Phone _____ Work Phone _____ Cell Phone _____
Age _____ Date Of Birth _____ Social Security # _____
Emergency Contact Name _____ Emergency Contact's # _____
Education/Last Grade Completed _____ Optional: Religion _____
Are You Employed? _____ Where? _____ FT/PT
Marital Status _____ # of years you have been together? _____
Partnter's Name_____ Partner's Employer _____
Is this your first marriage? _____ Your spouse's? _____
Children: Age Sex Living at home?

_____
_____
_____
_____
_____
_____

DYFS History (previous or present involvement) _____
_____
_____
Do you have any involvement with the legal system? _____
Does your partner have a criminal record? _____
(if you answered yes please explain) _____
Does your partner use drugs or alcohol? _____
(if you answered yes please explain) _____
Does your partner have a history of mental illness? _____
(if you answered yes please explain) _____
_____
_____

Please fill out if you or a family member have been in counseling or therapy before:

Person	Therapist/Agency	When/Duration	Reason

Have you or a family member ever been hospitalized for psychiatric reasons?

Person	Hospital	When/Duration	Reason

Please list your brothers and sisters:

Age	Sex	Marital Status	Drug/Alcohol History

Have you ever had a serious injury or illness? _____Yes _____No _____
If yes, please explain _____
Do you have any other medical problems? _____Yes _____No _____
If yes, please explain _____
Please list any medications you are taking: _____
_____

Do you or have you ever used alcohol while taking this or any other medication? ____Yes _____No
Do you ever see a new doctor because your regular doctor would not refill your prescription? Y/N
Has anyone in your family/friends expressed concern over your drinking or use of drugs? Y/N
Do you use alcohol at all? _____Yes _____No How often? _____
What do you like to drink? _____
Do you ever get drunk? _____Yes_____No_____
Do you ever drink alone? _____Yes_____No_____
Do you have trouble remembering things when you drink? _____ Yes _____ No _____
Do you think that alcohol or drugs are a problem for you? _____ Yes _____ No _____
If yes, please explain: _____
Do you have any other addictions (Gambling, Food, Etc.)? _____ Yes _____ No_____
If yes, please explain: _____

Are you currently in a recovery program? Yes _____ No_____

If yes, which one? _____

PLEASE CIRCLE ALL AREAS OF CONCERN TO YOU:

1. PHYSICAL ABUSE
2. EMOTIONAL ABUSE
3. SEXUALITY
4. SEXUAL ASSAULT
5. DEPRESSION
6. ANXIETY
7. RELATIONSHIPS
8. SELF-ESTEEM
9. PARENTING
10. BEHAVIOR OF CHILDREN
11. SEPARATION / DIVORCE
12. FINANCES
13. LEGAL ISSUES
14. GAMBLING
15. ANGER MANAGEMENT
16. SELF-ABUSE
17. PHYSICAL ABUSE OF CHILDREN
18. EMOTIONAL ABUSE OF CHILDREN
19. SUICIDAL THOUGHTS
20. HOMICIDAL THOUGHTS
21. HEALTH CONCERNS
22. FEAR OF MENTAL INSTABILITY
24. ALCOHOL USE BY ___ME____PARTNER_____CHILD_____PARENT
25. DRUG USE BY _____ME_____PARTNER_____CHILD_____PARENT
26. EATING DISORDER_____ANOREXIA_____BULEMIA_____OVEREATING

In the space below briefly describe what brings you to counseling at this time.

_____
_____
_____
_____
_____
_____
_____

Please read over the list of drugs on the next four pages and place a check next to any you have used in the past or are presently using.

ANTI-ANXIETY

	PRESENT USE	PAST USE
ATIVAN		
BUSPAR		
KLONOPIN		
LIBRIUM		
VALIUM		
XANAX		
OTHER		

ANTI-DEPRESSANTS

	PRESENT USE	PAST USE
CELEXA		
DESPIRAMINE		
ELAVIL		
EFFEXOR		
GEODON		
LITHIUM/ ESKALITH		
LUVOX		
PAMELAR		
PAXIL		
PROZAC		
SERZONE		
TOFRANIL		
WELLBUTRIN		
ZOLOFT		
LEXAPRO		
OTHER		

ANTI-PSYCHOTICS

PRESENT USE PAST USE

CLOZARIL _____
RISPERDAL _____
ZYPREXA _____
SEROQUEL _____
THORAZINE _____
OTHER _____

MOOD STABILIZERS

PRESENT USE PAST USE

DEPAKOTE _____
LITHIUM _____
NEURONTIN _____
REMERON _____
TEGRETOL _____
TOPIMAX _____
OTHER _____

SLEEPING PILLS

PRESENT USE PAST USE

AMBIEN _____
HALCION _____
PLACIDYL _____
RESTORIL _____
TRAZODONE _____
OTHER _____

PAIN KILLERS

PRESENT USE PAST USE

CODEINE _____
DARVON _____
DEMEROL _____
DILAUDID _____
FIORNAL _____
MORPHINE _____
PERCODAN/ PERCOCET _____
OXYCODONE _____
VICODAN _____

OTHER DRUGS

	PRESENT USE	PAST USE
BARBITUATES		
COCAINE/CRACK		
CRYSTAL METH		
GHB		
PCP/ ECSTACY/ SPECIAL K		
HEROIN		
METHADONE		
ROPHYPHOL/ ROOFIES		
SPEED		
STEROIDS		
TOBACCO		
OVER THE COUNTER		
OTHER		

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 (father, grandmother, uncle, etc.).

Please Circle & List Family Member

Alcohol/Substance Abuse yes/no
Anxiety yes/no
Depression 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:

1. Are you currently employed? ☒ No ☒ Yes
   If yes, what is your current employment situation:

_____

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

_____
_____

2. Do you consider yourself to be spiritual or religious? ☒ No ☒ Yes
   If yes, describe your faith or belief:

_____
_____
_____

3. What do you consider to be some of your strengths?

_____
_____
_____
_____

4. What do you consider to be some of your weakness?

_____
_____
_____
_____

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

_____
_____
_____