Mary Quirk, M.A., L.P.C., N.C.C.
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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

ANTI-PSYCHOTICS	PRESENT USE	PAST USE
CLOZARIL		
RISPERDAL		
ZYPREXA		
SEROQUEL		
THORAZINE		
OTHER		

MOOD STABILIZERS

MOOD STABILIZERS	PRESENT USE	PAST USE
DEPAKOTE		
LITHIUM		
NEURONTIN		
REMERON		
TEGRETOL		
TOPIMAX		
OTHER		

SLEEPING PILLS

SLEEPING PILLS	PRESENT USE	PAST USE
AMBIEN		
HALCION		
PLACIDYL		
RESTORIL		
TRAZODONE		
OTHER		

PAIN KILLERS

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?
   ____
   ____
   ____