Crosspath Counseling and Consultation

Client Intake Form

FOR CONFIDENTIAL USE ONLY

Primary Client Information

Client Name: _____ Date of Birth: _____ Age: _____ Gender: _____

Mailing Address: _____ City: _____ State: ____ ZipCode: _____

Home Phone: _____ Cell Phone: _____ Email: _____

If client is a minor, list parents/guardians: Preferred method for Appointment reminder: SMS Text / Email

Name	Relationship	Home Phone	Cell Phone

Billing Contact

Who is Financially responsible? _____

Mailing Address: _____ City: _____ State: _____ ZipCode: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Emergency Contact

Name: _____ Phone: _____ Relationship: _____

Primary Insured

Name: _____ Date of Birth: _____ Relationship: _____

Others Currently Living in Home

Name	Age	Relationship to Client

Referred to Crosspath Counseling By: _____ Phone: _____

Why are you seeking services? *List and prioritize the problems of greatest concern to you.*

Current or Past Problematic Symptoms *(Check all that apply)*

	Alcohol Use/Misuse		Euphoria/Elevated Mood		Job Problems		Relationship/Marital Problem
	Anger problems		Family Problems		Learning Disability		Sadness
	Avoidance/Withdrawal		Fatigue/Low Energy		Legal Problems		Self-Destructive Thoughts or Behaviors
	Authority Issues		Fear of Abandonment		Loss of Interest/Pleasure		Self-Sabotaging Behavior
	Bedwetting		Fear of Rejection		Low Self-Esteem		Separation Anxiety
	Binging/Purging		Financial Problems		Memory Problems		Shakiness
	Co-Dependence		Flashbacks		Muscle Tension		Shortness of Breath
	Crying (Occasional)		Gambling Problems		Nervousness/Anxiety		Sleeping Problems
	Crying (Frequent)		Grief/Loss		Nightmares		Strange Thoughts/Beliefs
	Crying (Uncontrollable)		Guilt		Obsessions/Compulsions		Stress
	Crying (Never)		Health Problems		Parent-Child Problems		Weight Gain
	Depressed mood		Hearing Voices		Passivity		Weight Loss
	Difficulty Concentrating		Hopelessness		Physical Pain		Worthlessness
	Dizziness		Hyperactivity		Physical/Emotional Sexual Trauma		Other *(please describe)* :
	Drug Use/Misuse		Impulsiveness		Physical Illness		
	Eating Issues		Irritability		Physical Pain		
	Edgy		Isolation		Rebelliousness		

Prior Psychiatric, Psychological or Chemical Dependency Services Received

Practitioner(s):	Type of Treatment	Dates of Services	Was it helpful?

Religion or Spiritual Affiliation

Do you currently practice? ☐ Yes ☐ No

Are there practices or beliefs that may affect or influence treatment? Please explain. _____

_____

Substance Use History

Substance	Amount Used in Last Month (example: 2 beers/day)	Amount Used in the Past (example: 2 beers/day)	N/A
Caffeinated Beverages			
Cigarettes			
Alcohol			
Marijuana			
Cocaine			
Amphetamines (Uppers)			
Barbiturates (Downers)			
Tranquilizers			
Hallucinogens			
Opiates			
Other, please describe:			

Family History - Medical, Psychiatric and Chemical Dependency

Condition	Circle	Family Member
Anxiety/Nervous Problems	Yes / No	
Depression	Yes / No	
Psychiatric Treatment	Yes / No	
Alcohol Abuse	Yes / No	
Prescription Drug Misuse	Yes / No	
Non-prescription Drug Misuse	Yes / No	
Non-prescription Drug Misuse	Yes / No	
Other: _____	Yes / No	

Medical Conditions (please list):

Current and Recent Medications

Medication	Dose	Prescribed for	Prescibing Physician

Primary Physician Name: _____ Address: _____

Phone: _____ Last Physical Examination: _____

Relationship History

Current Marital Status: ☐Single ☐Married ☐Partnered ☐Separated ☐Divorced ☐Widowed

If Married, Remarried,or Partnered, for how long? _____

If Divorced Separated or Widowed, for how long? _____

Educational History

Highest Level completed: _____