Life Discovery Counseling Services
Phone: 971.808.2686 | **Fax**: 866.802.8062
Email: contact@lifedcs.com
Web: LifeDCS.com

Confidential Client Intake Information

GENERAL INFORMATION

Full Name: ______________________________ Name You Prefer: ________________________

Date of Birth: _______________________ Age: __________ Sex: ☐ Male ☐ Female

Referred by: ____

CONTACT INFORMATION

Street Address: ____ Suite / Apt. #: __________

City: ___________________ State: _____ Zip: _________ OK to send mail here? ☐ Yes ☐ No

Home Phone: (___________)_______________________ OK to leave message here? ☐ Yes ☐ No

Cell Phone: (___________)_________________________ OK to leave message here? ☐ Yes ☐ No

Text Messaging: can we send text messages to your cell phone? ☐ Yes ☐ No

Email Address: ___________________________________ OK to send mail here? ☐ Yes ☐ No

EMERGENCY CONTACT

Name: ______________________________ Relationship: _________________________________

Home Phone: (_________)___________________ Cell Phone: (__________)____________________

EMPLOYMENT & EDUCATION INFORMATION

Employer: _________________________________ Length of Employment: ____________________

Occupation: ________________________________ Average Hours Worked Per Week: __________

Annual Household Income: _____________________ Highest Grade of Education: _____________

Are You Currently In School? ☐ Yes ☐ No If Yes, What Level: _______ Degree Pursuing: _______

RELIGIOUS BACKGROUND

Do you consider yourself: ☐ Atheist ☐ Agnostic ☐ Religious/Spiritual ☐ Other: _______________

How would you describe your religious/spiritual beliefs: _____________________________________

Do you regularly attend a place of worship? ☐ Yes ☐ No If yes, where? ____________________

Briefly describe the religious environment of the home you grew up in: _______________________

Complete the following thought: "God is ____"

RELATIONAL INFORMATION

Current Marital Status:

☐ Single ☐ Engaged ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

If Married, How Long? _________ # of Previous Marriages for You: _________ For Spouse: ________

If Separated or Divorced, How Long? _____________ If Widowed, How Long? _________________

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Who Do You Currently Live With? (Check All That Apply)

☐ Alone ☐ Spouse ☐ Parent(s) ☐ Sibling(s)
☐ Boyfriend ☐ Girlfriend ☐ Child(ren) ☐ Other: ____________

PARTNER INFORMATION (if applicable)

Full Name: ______________________________________ How Long Have You Been Together? __________

Age: _____ Sex: ☐ Male ☐ Female Occupation: ______________________________________

CHILDREN

Please list your children (living or deceased) as well as any children you have placed for adoption:

Name	Sex	Current Age or Year of Death	Relationship To You (Natural, Step, Adopted)	Living With You?	1-2 Word Description:

Have you ever had a miscarriage or medical abortion? ☐ Yes ☐ No If yes, when? _______________

Has your *partner* ever had a miscarriage or medical abortion? ☐ Yes ☐ No If yes, when? __________

FAMILY OF ORIGIN - SELF

Please list family members (immediate or extended family) who affected you positively or negatively:

Name	Relationship To You (Mom, Dad, Brother, Sister, Step, etc.)	Current Age or Year of Death	Occupation	2-4 Word Description:

Overall, your family life growing up was:

☐ Supportive ☐ Loving ☐ Chaotic ☐ Confusing ☐ Affirming
☐ Strict ☐ Hostile ☐ Safe ☐ Unsafe ☐ Negative

How did your family deal with conflict growing up:

☐ Yell or scream ☐ Physical aggression ☐ Talking/listening ☐ Ignoring *people*
☐ Ignoring *issues* ☐ Isolating (silent treatment) ☐ Safe ☐ Guilt or manipulation

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FAMILY OF ORIGIN – PARTNER (if applicable)

Please list family members (immediate or extended family) who affected you positively or negatively:

Name	Relationship To You (Mom, Dad, Brother, Sister, Step, etc.)	Current Age or Year of Death	Occupation	2-4 Word Description:

Overall, your family life growing up was:

☐ Supportive ☐ Loving ☐ Chaotic ☐ Confusing ☐ Affirming
☐ Strict ☐ Hostile ☐ Safe ☐ Unsafe ☐ Negative

How did your family deal with conflict growing up:

☐ Yell or scream ☐ Physical aggression ☐ Talking/listening ☐ Ignoring *people*
☐ Ignoring *issues* ☐ Isolating (silent treatment) ☐ Safe ☐ Guilt or manipulation

MEDICAL INFORMATION

Primary Care Physician: ___________________________ Phone: (__________)_____________________

Address: _________________________________ City: _____________________ Zip: _______________

Are you currently receiving medical treatment? ☐ Yes ☐ No If yes, please specify: ________________

Please list conditions, illnesses, surgeries, hospitalizations, traumas, or related treatments you've had:

____

____

MEDICATION INFORMATION

Please list all current medications you are taking, including those you seldom take or only as needed:

Medication	Dosage & Frequency	Improves, Prevents, or Controls (Symptoms)	Treating (Illness)

Are you taking these according to your doctor's recommendations? ☐ Yes ☐ No

If no, please briefly explain: ________________________________

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PHYSIOLOGICAL SYMPTOMS

Please check any of the following problems that apply to you (Self = X, Partner = O):

	X	O		X	O		X	O
Addiction			Impulsivity			Preoccupation with sex		
Anger			Infidelity or affair(s)			Prescription drug abuse		
Anxiety / Stress / Worry			Internet relationship(s)			Racing thoughts		
Appetite problems			Insomnia			Recurring thoughts		
Argumentative			Intrusive thoughts			Relationships		
Avoidance of responsibility			Irritability			Restlessness		
Blaming others			Joint/Muscle			Sadness or crying		
Cancer/Tumors			Lack of confidence			Secrets / hiding things		
Compulsions			Learning/Focus			Self-harm		
Concentration			Legal difficulties			Sexual abuse		
Depression			Loss of energy			Sexual difficulties		
Disordered eating			Memory			Sleeping problems		
Domestic violence			Medication issues			Social anxiety		
Emotional Abuse			Mood swings			Spiritual problem		
Employment			Nervousness			Stomach issues		
Excessive guilt			Nightmares			Substance abuse		
Extreme shyness			Night sweats			Thoughts of death		
Fear of leaving home			Obsessions			Tiredness or fatigue		
Financial Concerns			Panic			Trauma		
Frequent conflicts			Paranoia			Trauma flashbacks		
Hearing/seeing things			Personality disorder			Unable to keep friends		
Headaches or Dizziness			Phobias			Veteran/Military		
Head Injury			Physical abuse			Weight change		
Hypersomnia			Poor decisions			Worthlessness		
Hypertension			Pornography use			Other:		

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LIFE EXPERIENCES

Please check any of the following experiences you have had (Self = X, Partner = O):

	X	O		X	O		X	O
Adoption			Feeling numb			Natural disaster		
Avoiding unwanted thoughts			Feeling out of body			Not knowing where I am		
Bad memory			Feeling out of place			Parental divorce		
Basic needs not met			Frequently moving			Parental separation		
Been attacked			Head injury			Strong feelings of guilt		
Blacking out at times			Holes in my memory			Sudden life threatening illness		
Blank childhood memory			Hypervigilant			Thoughts causing nausea		
Crime victim			Known family history of physical/sexual abuse			Unusual thoughts or memories during sex		
Death in the family			Legal/court issues			Verbal, physical abuse		
Easily startled			Lived in combat area			Violence in home		
Feeling “checked out”			Living in constant fear			Waking up feeling lost		
Feeling “keyed up”			“Losing time” recently			Wondering who I am		

LEVEL OF DISTRESS

Indicate your level of distress on a 0-10 scale (0 = none; 10 = extreme): Self: _____ Partner: _____

Are you currently experiencing any suicidal thoughts? ☐ Yes ☐ No In the past? ☐ Yes ☐ No

Have you ever attempted suicide? ☐ Yes ☐ No If yes, when and how? ________________________

Have any family or friends ever attempted or committed suicide? ☐ Yes ☐ No

If yes, who and when? ____

PRESENTING ISSUES AND GOALS

Please describe why you are coming to counseling (e.g., What are your issues/problems?)

____

____

Why did you decide to come to counseling now? ____

____

What do you hope to gain by coming to counseling? ____

____

How long do you believe counseling will (or should) last?______________________________________

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PREVIOUS COUNSELING

Please list any prior counseling, psychiatric treatment, or residential/inpatient care you have received:

Therapist: ______________________________ Location: ____
Dates: _________________________________ Reason: ____

Therapist: ______________________________ Location: ____
Dates: _________________________________ Reason: ____

Therapist: ______________________________ Location: ____
Dates: _________________________________ Reason: ____

Therapist: ______________________________ Location: ____
Dates: _________________________________ Reason: ____

Therapist: ______________________________ Location: ____
Dates: _________________________________ Reason: ____