Victoria Easom, M.A., LPCI
Restore Counseling, LLC
27 Gamecock Ave., Suite 202
Charleston, SC 29407
843.608.0714

NEW CLIENT INTAKE FORM

PERSONAL/FAMILY RECORD:

Client Name: _____ Date: _____

Address: _____ DOB: _____

_____ Sex: _____

Email Address: _____

Employer: _____

Occupation: _____

Highest Level of Education Completed (please circle):

Some HS HS Diploma GED Some College Bachelor's Master's PhD

Marital Status (please check):
Single _____ Engaged _____ Married _____ How long? _____
Separated _____ How long? _____ Divorced _____ How long? _____
Widow/er _____ How long? _____

If married, Spouse's Name: _____

Spouse's Occupation: _____

If you have children, please list their names, age, and sex. Do they live in the home with you?

_____

_____

_____

_____

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How did you hear about us? Specify referral source if applicable. _____

COUNSELING HISTORY:

Have you ever been in counseling/therapy for any reason? **Y** or **N**

If so, when and for what reason?

_____

_____

_____

_____

How long were you in counseling/therapy? _____

Are you currently working with another Counselor, Psychologist, or Support Group? **Y** or **N**

If yes, please indicate reason & when you began?

_____

_____

_____

_____

INTEGRATION OF FAITH IN THERAPEUTIC PROCESS:

Please indicate below to describe how important faith/spirituality is in your life:

_____ Significant _____ Moderate _____ Very little _____ Not at all

Please indicate your desire for an integration of your faith/spirituality in counseling: **Y** or **N**

Comments: _____

_____

PHYSICAL HEALTH HISTORY:

Name & phone nr. of Primary Care Physician: _____

Are you currently taking any prescription drugs: **Y** or **N**

Please list any medications you are presently taking, including over the counter meds, herbal supplements, or vitamins: _____

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_____

_____

Please list any medication allergies: _____

How would you describe your physical health (please circle)?
Excellent Good Fair Poor

Are you currently seeing any other wellness professionals? (Physical Therapist, Massage Therapist, Acupuncture, Chiropractor, etc.) **Y** or **N**

If **Y**, please indicate: _____

Do you use tobacco? **Y** or **N**
If **Y**, please indicate type & frequency of use: _____

Do you drink alcohol? **Y** or **N**
If **Y**, please tell me what you typically drink, the average number of drinks consumed, and how frequently you drink.

_____

_____

Have you ever used drugs? **Y** or **N**
If **Y**, please indicate type & frequency of use: _____

Do you currently use drugs? **Y** or **N**
If **Y**, please indicate type & frequency of use: _____

Have you ever participated in any type of alcohol/drug treatment? **Y** or **N**
If **Y**, indicate name of program & length of time enrolled: _____

_____

PSYCHIATRIC/BEHAVIORAL HEALTH HISTORY:
Have you ever been admitted to an inpatient psychiatric facility, mental hospital, or other mental health facility? **Y** or **N**
If **Y**, for what reason? _____
When? _____ Where? _____

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Have you ever discussed past or current problems with a physician or other Mental Health Professional?
Y or **N**

If **Y**, please indicate dates, nature of concern, type of professional consulted, & result:
_____

Are you currently prescribed any psychotropic medications? **Y** or **N**
If **Y**, list start date, name, & dosage for each medication prescribed:
_____

Have you been prescribed any psychotropic medications in the past? **Y** or **N**
If **Y**, list start date, name, & dosage for each medication prescribed:
_____

Do you have thoughts or plans to harm or kill yourself or someone else? **Y** or **N**
If **Y**, please explain: _____
_____

Has anyone in your family been treated for psychiatric issues or been admitted to a mental hospital or inpatient psychiatric facility? **Y** or **N**

If **Y**, indicate relationship to you & your knowledge of treatment: _____
_____

Has any member of your family or any close friend committed suicide? **Y** or **N**
If **Y**, please explain: _____

Do you have a history of:	Physical Abuse?	**Y** or **N**
	Sexual Abuse?	**Y** or **N**
	Domestic Violence?	**Y** or **N**

SOCIAL HISTORY:
Where were you born? _____ Raised? _____
How often did you move as a child? _____
Is you Father living? **Y** or **N** Is your Mother living? **Y** or **N**
If **Y**, where? _____ If **Y**, where? _____

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How would you describe your relationship with your father (please circle)?
Excellent Good Fair Poor Non-Existent

How would you describe your relationship with your mother (please circle)?
Excellent Good Fair Poor Non-Existent

Who lived in your childhood household? _____
_____

Number of brothers: _____ Number of sisters: _____ Your Birth Order: _____

Are your parents divorced? **Y** or **N**
If **Y**, what was your age at the time? _____

As a student, did you struggle academically or socially? **Y** or **N**
If **Y**, please describe: _____

Did you have difficulty getting along with peers or teachers? **Y** or **N**
If **Y**, please describe: _____

Were you ever placed on probation (academic or otherwise), suspended, or expelled from school?
Y or **N**
If **Y**, please explain: _____

Have you ever or do you now experience difficulty getting along with your employer or coworkers?
Y or **N**
If **Y**, please describe: _____

CURRENT CONCERNS:
Please explain what brings you here today or the reason for your referral:

_____

_____

_____

_____

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How long has this been a problem? _____

Describe your current mood: _____

Nature of *current major stressors* (please circle all that apply):

Marital Family Financial Legal

Other(s): _____

Tell me briefly what you have been doing to address the issues that bring you in today:

_____

_____

Please circle below if you have ever experienced any of the following & indicate the age of occurrence or onset:

	Age		Age
Depression		Anger	
Worrying		Anxiety	
Fear		Panic	
Nightmares		Bed Wetting	
Blackouts		Excessive Drug Use	
Eating Problems		Excessive Alcohol Use	
Sleep Problems		Auditory/Visual Hallucinations	
Sexual Issues		Feelings of Persecution	

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Stuttering/Stammering		Reckless Driving	
Fire Setting		Thoughts of Harming Others	
Stealing		Thoughts of Harming Yourself	
Excessive Caffeine Use		Running Away	
Feeling that you are a Loner		Sexual Abuse	
Physical Abuse		Verbal Abuse	
Animal Cruelty		Irritability	