LifeCare Counseling
Psychotherapy Services — Caring for You and Your Life

CLIENT INTAKE FORM

Adult-Biopsychosocial History

1293 Professional Drive, Suite A-101
Myrtle Beach, SC 29577
843.282.9004 office 843.808.6905 fax
lifecare@mylifecarecounseling.com

CLIENT INFORMATION

Client Name *(Last, First, M.I.)*:	☐ M ☐ F	Date of Birth:	
Address:			
City:		State:	Zip:
Email:	Would you like to be on our mailing list? ☐ Y ☐ N		
Phone: (H)	(W)	(Cell)	
Employer:	Occupation:		
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed			
Spouse/Partner:	☐ M ☐ F	Age:	Date of Birth:
Emergency Contact:	Relationship:	Cell: Home Phone:	
What are your Scheduling Preferences?			
How did you hear about LifeCare Counseling?			

BILLING INFORMATION

Person responsible for bill (if not the client):			
Birth date:	Home phone:	Cell phone:	
Address (if different):	City:	State:	Zip:

INSURANCE INFORMATION

Do you have insurance?		☐ Yes ☐ No	
Primary Insurance Provider:		Type of Insurance Plan:	
Subscriber's name:			Birth date:
Policy/ID #:		Group #:	
Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other			
Subscriber's Occupation:		Employer:	
Employer address:			Employer phone:

THERAPY NEEDS

What would you like therapeutic support with?

- ☐ Anxiety
- ☐ Depression
- ☐ PTSD/Trauma
- ☐ Grief/Loss
- ☐ Mood Disorder
- ☐ Fears/Phobias
- ☐ Marital/Relational
- ☐ Work/School/Home Issues
- ☐ Parenting Difficulties
- ☐ Stress Management
- ☐ Anger Management
- ☐ Substance Abuse
- ☐ Life Transitions
- ☐ Life Coaching (Personal Development)
- ☐ Self-Esteem
- ☐ Codependency
- ☐ Other ______________________

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Client History

What presenting problems/concerns bring you to counseling at this time?

What would you like to be different as a result of counseling/What are your counseling goals?

Mental Health History

Have you experienced any of the following within the past 90 days? (Please check all that apply)

- ☐ Anxiety
- ☐ Depression
- ☐ PTSD/Trauma
- ☐ Grief/Loss
- ☐ Relational Difficulties
- ☐ Sleep Disruptions
- ☐ Appetite Changes
- ☐ Declined Functioning
- ☐ Declined Hygiene habits
- ☐ Anger/Irritability
- ☐ Obsessive/Ruminating Thoughts
- ☐ Substance Abuse
- ☐ Self-Injury
- ☐ Suicidal Thoughts
- ☐ Suicidal Attempts
- ☐ Psychosis/Delusions
- ☐ Thoughts of Harming Others
- ☐ Violent/Aggressive Behaviors

Have you ever been in counseling before? ☐ Yes ☐ No
If yes, please complete the section below.

Dates	Counselor Name

Are you currently taking mental health medications? ☐ Yes ☐ No
If yes, please list: ______________________________

If yes, please list: ______________________________

Have you ever been admitted into a hospital for behavioral health reasons? ☐ Yes ☐ No
If yes, please complete the section below.

Date(s)	Location

Is there any family history of mental health problems or suicide (attempts)? ☐ Yes ☐ No

If yes, please explain:

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Trauma, Grief & Loss History

Do you have a history of trauma, grief, or loss?
If yes, please share below.

____

____

____

Medical History

Who is your Primary Care Provider?

Do you currently have any medical conditions or problems? ◻ Yes ◻ No

If yes, please describe: ______________________________

____

____

Approximately, how long have you had medical condition(s)?

Have you recently experienced any appetite changes? ◻ Yes ◻ No

Have you recently had a gain or loss of over 10 pounds? ◻ Yes ◻ No

How are your sleep patterns? ______________________________
(Adequate Sleep, Not Enough, Erratic)

Employment/Education Summary

Are you currently employed? ◻ Yes ◻ No
If yes, please complete below.

Occupation	Employer	Length of Employment

Are you satisfied with your employment ◻ Yes ◻ No

What is your highest level of education completed? ______________________________

Are you currently a student? ◻ Yes ◻ No
If yes, please complete below:

School	Program/ Grade Level
______________________________	______________________________

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Legal Summary

Are you experiencing any legal issues (current or past 2 years? ☐ Yes ☐ No

Are you court ordered for services? ☐ Yes ☐ No If no, please skip to the next section.

Are you currently assigned to a probation officer or caseworker? ☐ Yes ☐ No

If yes: | Name: Phone Number: ______

Will you require progress reports for legal authorities? ☐ Yes ☐ No

Substance Use Summary

Have you ever used or are you currently using any substances? ☐ Yes ☐ No

Have you ever felt guilt or remorse about your substance use? ☐ Yes ☐ No

Have you ever tried to stop and have been unsuccessful? ☐ Yes ☐ No

If yes, please share more below:

______

______

Family History

Who were you raised by? ______

Please describe your relationship with your parents/caregivers. ______

______

______

How many siblings do you have? ______

Please list names, ages, and respective relationships with your siblings:

______

______

______

______

Are you living with your spouse or partner at present? ☐ Yes ☐ No

Please describe your relationship with your spouse or partner ______

______

Do you have any children? ☐ Yes ☐ No

If yes, please complete the section below.

Name of Child	Age	Relationship with Child

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Social/Support System

Describe your support system (i.e., family, friends, etc.).

____

Who do you share your inner most concerns with most often (Emotional Support Person)?

____

What are your hobbies, leisure activities?

____

Are you satisfied with your social/support system? ☐ Yes ☐ No
If no, please explain why. ____

Living Situation/Financial

How would you describe your current living situation? ☐ Stable ☐ Unstable ☐ Temporary ☐ Other:

Are there any safety concerns at home ☐ Yes ☐ No

If yes please explain ____

Are there financial circumstances creating/exacerbating issues with your mental health and/or in your relationships?

____

Personal Strengths/Growth Areas

What are your Strengths & Growth Areas?

Strengths:

____

Growth areas:

____

Thank you for completing this intake form. Please sign & date below.

CLIENT SIGNATURE: ______________________________ **Date:** ______________