McClintock Therapies

Client Intake Form

Name:_____ DOB: _____

Address:_____

Parent/Guardian Name: _____

Email: _____

What brings you to counseling at this time? Is there something specific, such as a particular event? Be as detailed as you can:

_____

What are your goals for counseling?

_____

Have you seen a mental health professional before? If so, why and for how long?

_____

Specify all medications and supplements you are presently taking and for what reason:

_____

If taking prescription medication, who is your prescribing MD? Please include type of MD, name and phone number:

_____

Who is your primary care physician? Please include name and phone number:

_____

Do you drink alcohol? If so, how often:

_____

Do you use recreational drugs? If so, how often:

_____

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Do you have suicidal thoughts?

_____

Have you ever attempted suicide?

_____

Do you have thoughts or urges to harm others?

_____

Have you ever been hospitalized for a psychiatric issue?

_____

Is there a history of mental illness in your family? If so, please describe:

_____

Describe your current living situation. Do you live alone, with others, etc:

_____

What is your current job? What do you do? How long have you been doing it?

_____

Please select any of the following you have experienced in the past six months:

☐ Increased Appetite	☐ Low Motivation	☐ Anxiety
☐ Decreased Appetite	☐ Isolation	☐ Fear
☐ Trouble Concentrating	☐ Fatigue/Low Energy	☐ Hopelessness
☐ Difficulty Sleeping	☐ Depressed Mood	☐ Panic / Panic Attacks
☐ Excessive Sleep	☐ Tearful or Crying Spells	☐ Other

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Please select any of the following that apply:

- ☐ Headache
- ☐ High Blood Pressure
- ☐ Gastritis or Esophagitis
- ☐ Hormone Related Problems
- ☐ Head Injury
- ☐ Angina or Chest Pain
- ☐ Irritable Bowel
- ☐ Chronic Pain
- ☐ Loss of Consciousness
- ☐ Heart Attack
- ☐ Bone or Joint Problems
- ☐ Seizures
- ☐ Kidney Related Issues
- ☐ Chronic Fatigue
- ☐ Dizziness
- ☐ Faintness
- ☐ Heart Valve Problems
- ☐ Urinary Tract Problems
- ☐ Fibromyalgia
- ☐ Numbness and Tingling
- ☐ Shortness of Breath
- ☐ Diabetes
- ☐ Hepatitis
- ☐ Asthma
- ☐ Arthritis
- ☐ Thyroid Issues
- ☐ HIV/AIDS
- ☐ Cancer
- ☐ Other

Is there anything else you would like me to know?