BELL CENTER FOR ANXIETY AND DEPRESSION

Client Intake Form

Client Name: _____ Date: _____

Describe the problem that brought you here today: _____

_____

WORK/SCHOOL

□ Career choice
□ Financial concerns
□ Lack of motivation
□ Difficulties at work
□ Problems making decisions
□ Other:_____
□ Personality conflicts
□ Overwork/stress

HEALTH CONCERNS

□ Weight change
□ Eating pattern disorder
□ Tired/Fatigue
□ Concerns about drugs
□ Change in appetite
□ Poor memory/confusion
□ Bingeing
□ Difficulty sleeping
□ Headaches
□ Concerns about alcohol
□ Easily distracted
□ Other:_____
□ Purging
□ Lack of energy
□ Dizziness
□ Nightmares
□ Hyperactivity

PERSONAL CONCERNS

□ Suicidal thoughts
□ Self-injuring behaviors
□ Anxious
□ Unhappy
□ No self-confidence
□ Feeling anger
□ Dealing with loss
□ Impulsivity
□ Crying spells
□ Trouble concentrating
□ Feeling panicky
□ Sensitive
□ Anxious/Worried
□ Not feeling at all
□ Obsessive thoughts
□ Loss of pleasure/interest
□ Boredom
□ Other:_____
□ Depressed
□ Feeling inferior
□ Feelings easily hurt
□ Fearful
□ Dealing with death
□ Compulsive behaviors
□ Feeling guilt/shame
□ Mood swings

SOCIAL RELATIONSHIPS

□ Shy with people
□ Difficulty making friends
□ Withdrawing from others
□ Other:_____
□ Problems maintaining a relationship
□ Feeling lonely
□ Frequent arguments
□ Difficulty relating to people
□ Fighting in personal relationships

FAMILY RELATIONS/SPOUSE

□ Sexual concerns
□ Verbal abuse
□ Divorce
□ Marital concerns
□ Physical abuse
□ Other:_____
□ Fighting
□ Financial stress

FAMILY RELATIONS/CHILDREN

□ Behavior problems at [ ] Home [ ] School
□ Academic problems
□ Health Problems
□ Drug or alcohol abuse
□ Other:_____
□ Victim of Abuse
□ Divorce

FAMILY RELATIONS/PARENTS

□ Care-giver stress
□ Conflict over child raising
□ Financial concerns
□ Impending loss of loved one
□ Fighting
□ Other:_____

PERSONAL GOALS

□ Develop assertiveness skills
□ Develop clearer personal identity
□ Clarify personal goals and values
□ Develop more realistic self-expectations
□ Increase awareness of emotional response
□ Accept personal limitations
□ Develop coping skills
□ Other:_____

Are your problems affecting any of the following areas?

□ Everyday tasks □ Housing □ Health
□Work/school □ Sexual activity □ Hygiene
□ Recreational activities □ Relationships □ Finances
□ Self esteem □ Legal matters

Have you ever had thoughts, made statements, or attempted to hurt yourself? □ Yes □ No

If yes, please describe: _____

Have you ever had thoughts, made statements, or attempted to hurt someone else? □ Yes □ No

If yes, please describe: _____

Have you recently been physically hurt or threatened by someone else? □ Yes □ No

If yes, please describe: _____

Please check if you have experienced any of the following types of trauma or loss:

□ Emotional abuse □ Neglect □ Lived in a foster home
□ Sexual abuse □ Violence in the home □ Multiple family moves
□ Physical abuse □ Crime victim □ Homelessness
□ Parent substance abuse □ Parent illness □ Loss of a loved one
□ Teen pregnancy □ Placed a child for adoption □ Financial problems

Previous Mental Health Treatment

Yes	No	Type of Treatment	When?	Provider/Program	Reason for Treatment
		Outpatient Counseling			
		Medication (Mental Health)			
		Psychiatric Hospitalization			
		Alcohol/Drug Treatment			
		Self-Help/Support Groups			

Medical Information

Date of last physical exam: _____

Have you experienced any of the following medical conditions during your lifetime?

□ Allergies □ Meningitis □ Sleep disorder
□ Chronic pain □ Diabetes □ Stomach aches
□ Dizziness/fainting □ Abortion □ Head injury
□ High fevers □ Headaches □ Vision problems
□ Sexually transmitted disease □ Serious accident □ Miscarriage
□ Asthma □ Seizures □ Other: _____
□ Surgery □ Hearing problems

Please list any CURRENT health concerns: _____

Current prescription medications:

Medication	Dosage	Date First Prescribed	Prescribed By

□ No Prescription Medications

Please list any current over-the-counter medications (including vitamins, herbal remedies, etc.): _____

_____