THE COUNSELING
CENTER OF MARYLAND

8030 Woodmont Avenue, 3rd Floor | Bethesda, MD | 20814 | www.CounselingCenterofMaryland.com

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CONFIDENTIAL CLIENT INTAKE FORM

Name: _____ Age: _____ Date of Birth: _____

Gender: Male Female Transgender M to F Transgender F to M Non-binary

Preferred Pronouns: She/her He/him They/them Other (specify): _____

Home Address: _____

Mailing address if different than home: _____

Email Address: _____ May we email you? Yes No

Best Contact Phone Number: _____ May we leave a message? Yes No

Emergency Contact: _____ Relationship: _____ Phone: _____

SOCIOCULTURAL BACKGROUND

Racial/Ethnic Background:

White/Caucasian African-American Asian -American Asian or Pacific Islander Hispanic-American
Latino/Latin American/Hispanic Arab-American Native American Other (specify): _____

How much do you identify with your ethnic heritage?

Not at all A little Somewhat Moderately Strongly

Do you identify yourself in other ways that are meaningful to you (e.g., cultural background, sexual orientation, class status, special ability)? Please list: _____

_____

Religious Preference: _____

Are you currently active in your religion? Yes No Somewhat

ACADEMIC / WORK BACKGROUND

Current employer: _____ Title: _____

Hours worked per week: _____ Years with employer: _____

Are you satisfied with your job? Yes No Somewhat

Highest Educational Degree: _____ Major: _____

Are you currently a student? Yes No If yes, where? _____

RELATIONAL / SUPPORT HISTORY

Current relationship status: Single In a Committed Relationship Living with Partner Married Separated Divorced Widowed Other (specify): _____

If you are in a romantic relationship, have you or your partner had previous marriage(s)?

I have My partner has

If you are in a romantic relationship, how long have you been in this relationship? _____

Approximately how many significant romantic relationships have you had? _____

Are you satisfied with your current romantic status? Yes No Sometimes

How would you rate the quality of your friendships?

Very Poor Unsatisfactory Average Good Excellent

Besides family, how many people do you feel that you can share most of your feelings and experiences with? _____

Besides family, how many people can you count on right now for friendship/emotional support? _____

FAMILY BACKGROUND

Please list the family members living with you, their genders, occupations, and ages:

Family Member	Gender	Occupation	Age

How much conflict do you currently feel with your family (whether living with you or not)?

None Very little Some Moderate Strong Very strong

Who in your family do you currently feel closest to? _____

Most distant from? _____ In most conflict with? _____

In your family (whether they live with your or not), how many people do you feel that you can share most of your feelings and experiences with? _____

In your family (whether they live with your or not), how many people can you count on right now for emotional support? _____

PHYSICAL HEALTH

How is your physical health at present?

Poor Unsatisfactory Satisfactory Good Excellent

When was your last physical examination? _____

Please list any persistent physical symptoms or health concerns (e.g. chronic pain, sleep disturbances, headaches, hypertension, diabetes, etc.): _____

_____

Do you have a disability? Yes No If yes, specify: _____

Please list any prescribed medication:

Medication	Reason for prescription	Prescribing physician

Name of your primary care physician: _____

Are you having any problems with your sleep habits? Yes No

Are you having any difficulty with appetite or eating habits? Yes No

Have you had significant weight change in the last 2 months? Yes No

Do you have any problems or worries about sexual functioning? Yes No

How many times per week do you exercise? _____ For how long each time? _____

What do you do for relaxation? _____

_____

MENTAL HEALTH HISTORY
Please leave any sections blank that you do not feel comfortable completing

Have you ever been a victim of:

Emotional abuse as a child Physical abuse as a child Sexual molestation/abuse as a child

Emotional abuse by a partner/spouse Physical abuse by a partner/spouse

Sexual abuse/assault as an adult

Other Trauma: _____

Have you received counseling before? Yes No

If yes, where: _____ When: _____ Duration: _____

What was the focus of the previous counseling?

_____

Did you find it helpful? Yes Somewhat No

Were you ever prescribed psychiatric medications? Yes No

If yes, what medication(s) and for what reason?

_____

_____

Have you ever been hospitalized for psychological reasons? Yes No

Reasons: _____ Dates: _____

Are you presently having suicidal thoughts? Frequently Sometimes Rarely Never

Are you having thoughts of harming others? Frequently Sometimes Rarely Never

Have you ever intentionally inflicted harm on yourself? Yes No

Have you ever attempted suicide? Yes No If yes, date(s): _____

ALCOHOL AND OTHER DRUG USE:

How often do you drink alcohol?

Daily 3 + drinks per week 1-2 drinks per week Weekly Monthly Rarely Never

In a typical week, on how many days do you have 4 or more drinks? _____

How often do you use other drugs (marijuana, cocaine, ecstasy, oxycotin, etc)?

Daily 3 + times per week 1-2 times per week Weekly Monthly Rarely Never

Do you, or someone else, think that you may need to cut down on alcohol or drugs?

Yes No Maybe

PROBLEM ANALYSIS

Briefly describe the problem you are seeking help with right now:

_____

_____

_____

How would you rate the intensity of the problem that brought you in?

1 (not intense) 2 3 4 5 6 (extremely intense)

How much has your current problem interfered with your life in general?

Not at all A little Somewhat Moderately To a great extent

How many counseling sessions do you anticipate needing?

1-3 4-6 7-9 10-12 13-15 16-20 20+

In what ways have you tried to cope with this problem so far?

_____

_____

_____

How motivated are you to resolve this problem?

Not at all A little Somewhat Moderately Extremely

Why have you decided that now is the time to take action to resolve this problem?

_____

_____

How hopeful are you that this problem can be resolved?

Not at all A little Somewhat Moderately Extremely

List the strengths and qualities you admire about yourself:

_____

_____

_____

List the areas you would like to improve upon yourself:

_____

_____

_____

When our work together has been successful, what differences will you notice in yourself? In your life?

_____

_____

_____

I verify that the above information is accurate to the best of my knowledge

_____ _____ _____

Client Name Client Signature Date