VITAL INSIGHT COUNSELING

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Client Information and Intake Form

Date _____

How did you find out about Stephanie/The VIC center? _____

Name _____**Date of Birth** _____

Address _____

City _____ **State** _____ **Zip** _____ **Phone (cell/home/work)** _____

Email Address _____

Preferred Mode of communication ☐ **Email** ☐ **Phone**
** Email and texts correspondence is not guaranteed to be a confidential mode of communication*

Employer Name _____ **Occupation** _____

1. **What is your ethnicity/race?** _____
2. **Who do you live with?** _____
3. **Who is your support system?** _____
4. **Emergency Contact?** _____ **Phone** _____
5. **Do you have siblings?** ☐ **Yes** ☐ **No**

   How many sisters? _____ **List ages** _____

   How many brothers? _____ **List ages** _____
6. **Do you have children?** ☐ **Yes** ☐ **No**

   How many daughters? _____ **List ages** _____

   How many sons? _____ **List ages** _____
7. **Are you currently in a relationship?** ☐ **Yes** ☐ **No**

   Status: ☐ **Married/Partner** ☐ **Living together** ☐ **Dating** ☐ **Separated** ☐ **Poly**

   How long in the current relationship?_____

   Number of Divorces: _____
8. **Are you currently taking any psychiatric medication(s)?** ☐ **Yes** ☐ **No**

If yes, please list: _____

Prescriber: _____ **Current Provider?** ☐ **Yes** ☐ **No**

Will you sign a Release of Information for the above provider? ☐ **Yes** ☐ **No**

9. **Have you ever been treated at a psychiatric hospital?** ☐ **Yes** ☐ **No**

   If yes, dates and facility: _____

10. **Have you ever had counseling/therapy before?** ☐ **Yes** ☐ **No**
    If Yes: When and how long? _____

11. **Are you currently seeing another therapist?** ☐ **Yes** ☐ **No** **Purpose:** _____

    Will you sign a Release of Information for the above provider? ☐ **Yes** ☐ **No**

12. **Are you currently having any thoughts of hurting yourself or others?** ☐ **Yes** ☐ **No**

    If yes please describe: _____

    _____

    _____

13. **Do you drink alcohol?** ☐ **Yes** ☐ **No**

    How many times per week? _____ **Drinks per sitting:** _____

14. **Do you use any other substance?**

    Substance: _____ **Per week?** _____ **Amount:** _____

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    Substance: _____ **Per week?** _____ **Amount:** _____

15. **Do you need help decreasing your use?** _____

16. **How would you rate your overall physical health?**

    ☐ **Excellent** ☐ **Very good** ☐ **Good** ☐ **Not very good** ☐ **Poor**

    Please list any medical issues you have: _____

    _____

    Current Treatment Provider: _____

    Will you sign a Release of Information for the above provider? ☐ **Yes** ☐ **No**

15. **Have you recently experienced any significant life changes or stressful events?** ☐ **Yes** ☐ **No**

    If yes, please describe: _____

    _____

    _____

16. **Is there anything else you would like to share that you think would be helpful for me to know:**

    _____

    _____