OAK CREEK RELATIONAL COUNSELING CENTER
CLIENT INTAKE FORM

Welcome to our clinic. Please fill out this form as accurately as possible so we may best serve you. You may notice we ask for a variety of personal information. If any of the following raises concern or if you have questions, or if you have questions, your therapist is prepared to discuss any of the items on this form with you.

NAME:_____
(First) (Last) (Middle Initial)

- Birth Date _____/_____/_____Age_____

Home Address _____
(Number/Street/Zip Code)

- Contract Phone Number_____
- May we leave a message at this number?_____
- Emergency Contact_____
(Name) (Phone Number)

Please provide names and birthdates of all who reside in your home.

Name:_____DOB_____Male or Female

Name:_____DOB_____Male or Female

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Circle All That Apply

Preferred Pronouns	Relationship Status	Living Status
He	Single	Alone
She	Dating	Partner/Spouse
They	Partnered	Roommates
Ze	Married	With Children
A pronoun not listed	Widowed	Parents
No Preference	Poly/Open	Transitional
	Decline to answer	Homeless

Do you feel safe in your current living situation? _____

- If no, please explain.

_____

_____

Do you feel safe in your current relationship?

- If no, please explain.

_____

_____

Have you previously received mental health services? _____

- If yes, what kind of services?

_____

_____

Have you ever thought about committing suicide? _____

- If yes, do you continue to have these thoughts? _____

Have you ever attempted suicide? _____

- If yes, when and what happened?

_____

_____

- If yes, was a CFS or Police report filed? _____

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Medical History (circle all that apply)

Sleep Problems	Asthma	Withdrawal	High/low Blood Pressure
Heart Problems	TB	Head Injury	Loss of Consciousness
Skin Problems	Surgeries	Pregnancy	Weight Fluctuation
Urinary Problems	STD	Diabetes	Drug Reactions
Vision Problems	Seizures	Hep/Liver	Appetite Changes
Muscular Problems	Prosthesis	Osteopetrosis	Kidney Disease
Thyroid Problems	Allergies		
Hearing Problems	Cancer		

Current Medications:

_____

_____

Substance Use (Please circle or fill in)

TOBACCO	Never	Often	Daily	Other:
ALCOHOL	Never	Often	Daily	Other:
CAFFEINE	Never	Often	Daily	Other:
MARIJUANA	Never	Often	Daily	Other:

Other recreational drug use: Type/Frequency?

_____

_____

In the past 3 months, have you experienced any of the following? **(circle all that apply)**

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Bad Self Talk/ Critical of Self	Obsessive Behavior	Compulsive Behavior	Behavior Problems	Substance Abuse
Anger	Denial	Hyperactivity	Aggression	Threat to Others
Anxiety	Guilt	Irritability	Crying	Hyperarousal
Apathy	Fear	Depression	Nightmares	Eating Disorder
Avoidance	Panic	Dissociation	Insomnia	Memory Issue
Flashbacks	Phobia	Self-Blame	Self-Harm	Critical of Others
Self-destructive Relationships	Difficulty Concentrating	Somatic (body) Complaints	Emotional Numbing	Sexual Acting Out

Fee Agreement for service received at Oak Creek Relational Counseling Center: $_____.

Authorized Signature for insurance purposes: I authorize the release of any medical or other information necessary to process appropriate insurance claims. I authorize payment of mental health benefits to Oak Creek Relational Counseling Center.

Signed: _____Date: _____

Thank you for taking the time to fill out these forms. We look forward to working with you. **Oak Creek Relational Counseling Center**