Crosspath Counseling and Consultation

Client Intake Form

FOR CONFIDENTIAL USE ONLY. If more space is needed in any section, please feel free to submit additional documents

Primary Client Information

Client Name: _____ Date of Birth: _____ Age: _____ Gender Identity: _____

Birth Gender:_____ Sexual Orientation:_____ My pronouns are:_____

Mailing Address: _____ City: _____ State: ____ ZipCode: _____

Home Phone: _____ Cell Phone: _____ Email: _____

If client is a minor, list parents/guardians: Preferred method for Appointment reminder: EMAIL

Name	Relationship	Home Phone	Cell Phone

Billing Contact

Who is Financially responsible? _____

Mailing Address: _____ City: _____ State: _____ ZipCode: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Emergency Contact

Name: _____ Phone: _____ Relationship: _____

Primary Insured

Name: _____ Date of Birth: _____ Relationship: _____

Others Currently Living in Home

Name	Age	Relationship to Client

Referred to Crosspath Counseling By: _____ Phone: _____

Religion or Spiritual Affiliation

Do you currently practice? ☐ Yes ☐ No

Are there practices or beliefs that may affect or influence treatment? Please explain. _____

_____

Mental Health Concern Symptoms *(Check all that apply)*

☐ Alcohol Use/Misuse	☐ Euphoria/Elevated Mood	☐ Job Problems	☐ Relationship/Marital Problem
☐ Anger problems	☐ Family Problems	☐ Learning Disability	☐ Sadness
☐ Avoidance/Withdrawal	☐ Fatigue/Low Energy	☐ Legal Problems	☐ Self-Destructive Thoughts or Behaviors
☐ Authority Issues	☐ Fear of Abandonment	☐ Loss of Interest/Pleasure	☐ Self-Sabotaging Behavior
☐ Bedwetting	☐ Fear of Rejection	☐ Low Self-Esteem	☐ Separation Anxiety
☐ Binging/Purging	☐ Financial Problems	☐ Memory Problems	☐ Shakiness
☐ Co-Dependence	☐ Flashbacks	☐ Muscle Tension	☐ Shortness of Breath
☐ Crying (Occasional)	☐ Gambling Problems	☐ Nervousness/Anxiety	☐ Sleeping Problems
☐ Crying (Frequent)	☐ Grief/Loss	☐ Nightmares	☐ Strange Thoughts/Beliefs
☐ Crying (Uncontrollable)	☐ Guilt	☐ Obsessions/Compulsions	☐ Stress
☐ Crying (Never)	☐ Health Problems	☐ Parent-Child Problems	☐ Weight Gain
☐ Depressed mood	☐ Hearing Voices	☐ Passivity	☐ Weight Loss
☐ Difficulty Concentrating	☐ Hopelessness	☐ Physical Pain	☐ Worthlessness

☐ Dizziness	☐ Hyperactivity	☐ Physical/Emotional Sexual Trauma	☐ Other *(please describe)* :
☐ Drug Use/Misuse	☐ Impulsiveness	☐ Physical Illness	
☐ Eating Issues	☐ Irritability	☐ Physical Pain	
☐ Edgy	☐ Isolation	☐ Rebelliousness	

Medical Concerns *(Check all that apply)*

☐ Weight Loss/Gain	☐ High/Low Blood pressure	☐ Tremors	☐ Diarrhea
☐ Fever/Chills	☐ Cardiac problems	☐ Tics	☐ Abdominal pain
☐ Weakness	☐ Palpitations	☐ Numbness	☐ Rectal bleeding
☐ Trouble Sleeping	☐ Swelling/edema	☐ Impaired coordination	☐ Change in bowl habits
☐ Sleep Apnea	☐ Heart Murmer		☐ Yellow skin/eyes
☐ Snoring	☐ Atrial fibrillation	☐ Chronic muscle pain	☐ Anorexia
☐ Visual Impairment	☐ Sputum	☐ Neck/Back Pain	☐ Change in bowel/bladder control
☐ Eye pain	☐ Cough (dry/wet)	☐ Swelling	☐ Increase/decrease bathroom frequency
☐ Blurry/Double Vision	☐ Coughing up blood	☐ Joint pain	
☐ Flashing Lights	☐ Asthma	☐ Stiffness	
☐ Specks	☐ Wheezing	☐ Fibromyaglia	
☐ Glaucoma	☐ Painful breathing	☐ Broken Bone	
☐ Cataracts	☐ Lung disease	☐ Diabetes	
☐ Eye Redness	☐ COPD	☐ Sweating	
☐ Hearing problems	☐ Swallowing problems	☐ Heat/cold intolerance	
☐ Earache	☐ Heartburn/reflux	☐ Excessive thirst	
☐ Tinnitus (ringing ears)	☐ Nausea	☐ Change in appetite	
☐ Ear drainage	☐ Vomiting	☐ Hyperthyroid	
☐ Nose problems	☐ Diarrhea	☐ Hypothyroid	**Women:**
☐ Nose bleeds	☐ Abdominal pain	☐ Anemia	☐ Pregnant
☐ Sinus paid	☐ Rectal bleeding	☐ Easy bleeding/bruising	☐ Chance of being Pregnant
☐ Mouth/teeth/gum problems	☐ Change in bowl habits	☐ High cholesterol	☐ Plan to become pregnant
☐ Sore tongue	☐ Yellow skin/eyes	☐ Sickle cell	☐ Breastfeeding
☐ Dry mouth	☐ Fainting	☐ Platelet problem	☐ Contraception used
☐ Sore troat	☐ Burning w/urination	☐ Calf pain w/ walking	
☐ Hoarseness	☐ Dizziness	☐ Leg cramping	
☐ Thrush	☐ Incontinence	☐ Histoy of blood clots	Other Current Medical Issues
☐ Non-healthing Mouth Sores	☐ Blood in urine	☐ Cancer	
☐ Rash	☐ Painful intercourse	☐ HIV/AIDS	
☐ Lumps	☐ Sexual dysfunction	☐ Lupus	
☐ Itching	☐ STD	☐ Hx of step infections	
☐ Dryness	☐ Vaginal discharge	☐ Enlarged nodes	
☐ Skin color changes	☐ Hot flashes	☐ Hx of splenectomy	
☐ Hair/nail changes	☐ Headaches/Migraines	☐ Glasses/contacts	
☐ Eczema		☐ Hearing aids	
☐ Chest pain/discomfort			

Surgerical History (please list)

Long term Hospitalzation/Fequent ER Visits (please list)

History of Head injury/Loss of conciousness/Coma/Heart attak/Stroke (please explain)

History of seizures, tics, treamors or involuntary movements (please explain)

When your mother was pregnant with you, was there any problems? Once born, any problems meeting milestones?

If you have special diet of any kind, please explain

Prior Psychiatric, Psychological or Chemical Dependency Services Received

Practitioner(s):	Type of Treatment	Dates of Services	Was it helpful?

Reason for leaving past services:

Have you or a family member ever attempted suicide? (list last attempt/method/further explination)

Substance Use History

Substance	(example: 2 beers/day)	(example: 2 beers/day)	N/A
Caffeinated Beverages			
Cigarettes			
Alcohol			
Marijuana			
Cocaine			
Amphetamines (Uppers)			
Barbiturates (Downers)			
Tranquilizers			
Hallucinogens			
Opiates			
Other, please describe:			

Family History - Medical, Psychiatric and Chemical Dependency

Condition	**Select**	**Family Member**
Anxiety/Nervous Problems	NO	
Depression	NO	
Psychiatric Treatment	NO	
Alcohol Abuse	NO	
Prescription Drug Misuse	NO	
Non-prescription Drug Misuse	NO	
Other: _____		

Current and Recent Medications			
Medication	Dose	Prescribed for	Prescibing Physician

Primary Physician Name: _____ Address: _____

Phone: _____ Last Physical Examination: _____

Current Marital Status: ☐Single ☐Married ☐Partnered ☐Separated ☐Divorced ☐Widowed

If Married, Remarried,or Partnered, for how long? _____

If Divorced Separated or Widowed, for how long? _____

Educational History

Highest Level completed: _____

Miliary History

Field of service: _____