Clinical Counseling Services of Cincinnati
4055 Executive Park Drive, Suite 210
Cincinnati, OH 45241
513-469-6226

Today's Date_____

Client Intake Form

Client Name_____ DOB_____

Address_____ City_____ State_____ Zip_____

Home Phone_____ Email_____ Cell_____

Identified Gender: ☐Female ☐Male ☐Transgender ☐Other ☐Prefer Not to Answer

Identified Ethnicity ☐African American ☐Asian ☐Hispanic ☐Multiracial ☐Pacific Islander ☐White

Marital Status: ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed How long?_____

Employment Status ☐Full Time ☐Part-time ☐Student ☐Not working

Employer Name_____

Occupation_____ Phone_____

Spouse/Partner_____ DOB_____

Home Phone_____ Email_____ Cell_____

Employer Name_____Occupation_____

Children/Step Children: Name_____ DOB_____

Name_____ DOB_____

Name_____ DOB_____

Emergency Contact Name (if other than spouse/partner) _____

Relationship_____ Phone_____

Previous Counseling Treatment ☐No ☐ Yes Where_____ When_____

Please List All Current Medications, if applicable.

_____

Preferred Method of Communication ☐email ☐phone

Responsible Party Information

Insured's Name_____ DOB_____ ID# _____

Insurance Co._____ Phone _____

Employer_____ Phone _____

Did you preauthorize this visit ☐ No ☐Yes Authorization #_____

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Employment Assistance Program Name (EAP)_____

Phone _____

Referral Source_____

Religious/spiritual Information

Do you consider yourself to be religious? ☐No ☐Yes

If Yes, what is your faith_____

If No, do you consider yourself to be spiritual? ☐No ☐Yes

Family Mental Health History

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (Check any that apply and list family member, e.g., siblings, parents, uncle, etc.)

☐Depression
☐Bipolar Disorder
☐Anxiety Disorders
☐Panic Attacks
☐Schizophrenia
☐Alcohol/Substance Abuse
☐Eating Disorders
☐Learning Disabilities
☐Trauma History
☐Suicide Attempts

Health and Social Information

1. How is your physical health at present?
   ☐Poor ☐Unsatisfactory ☐Satisfactory ☐Good ☐Very Good
2. Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.)_____
   _____
3. Do you have any allergies? ☐ No ☐Yes Please explain _____
   _____
4. Do you smoke cigarettes? ☐No ☐Yes How much?_____

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5. Do you drink caffeinated beverages? ☐No ☐ Yes How much?_____
6. How many times per week do you exercise? _____ How long each time? _____
7. Alcohol Use ☐Daily ☐Weekly ☐Monthly ☐Rarely ☐Never

   Amount consumed? _____
8. How often do you engage in recreational drug use?

   ☐Daily ☐Weekly ☐Monthly ☐Rarely ☐Never
9. Have you previously been treated for substance abuse? ☐No ☐Yes
10. Are you currently in a romantic relationship? ☐No ☐Yes If Yes, how long_____

    On a scale of 1-10, how would you rate the quality of your current relationship _____
11. What is your sexual orientation?

    ☐Heterosexual ☐Homosexual ☐Bisexual ☐Pansexual ☐Queer ☐Questioning

    ☐Other ☐Prefer not to answer
12. In the last year, have you experienced any significant life changes or stressors? ☐No ☐Yes

    If yes, what were they:_____

    _____
13. Have you ever been physically or sexually abused? ☐No ☐Yes
14. Do you have military experience? ☐No ☐Yes _____

Have you ever experienced any of the following (check or circle all that apply)?

☐Extreme depressed mood
☐Mood swings
☐Rapid speech
☐Extreme anxiety
☐Panic attacks
☐Phobias
☐Sleep disturbances
☐Hallucinations
☐Unexplained losses of time
☐Homicidal thoughts
☐Unexplained memory lapses
☐Alcohol/Substance abuse
☐Frequent body complaints
☐Eating disorder
☐Body image problems
☐Repetitive thoughts (e.g., Obsessions)
☐Repetitive behaviors
(e.g., frequent checking hand-washing)
☐Suicide attempt

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OTHER INFORMATION

What do you consider to be your strengths?

_____

What do you like most about yourself?

_____

What are effective coping strategies that you've learned?

_____

What are your goals for therapy? _____