

ARBOR COUNSELING CENTER

CLIENT INTAKE CHECKLIST

Dear Client: To serve you better and help us make sure we will cover any areas of concern you may have, please circle your answer to each question below. Thank you for your cooperation.

Name: _____ Date: _____

Address: _____

Age/Birth Date: _____

- | | | |
|--|-----|----|
| 1) Do you have any current or history of medical conditions/illnesses? | Yes | No |
| If yes, explain _____ | | |
| 2) Are you on any current medications/treatment? | Yes | No |
| If yes, medication/treatment _____ | | |
| Physician name/phone _____ | | |
| 3) Are you having difficulty sleeping? | Yes | No |
| 4) Have you/others been concerned about your alcohol or drug use? | Yes | No |
| 5) Do any family members have alcohol or drug problems? | Yes | No |
| 6) Do you starve yourself or make yourself throw up? | Yes | No |
| 7) Do you have sexual concerns? | Yes | No |
| 8) Do you have thoughts about hurting yourself? | Yes | No |
| 9) Do you have any thoughts about hurting others? | Yes | No |
| 10) Do you feel you are in danger of being hurt? | Yes | No |
| 11) Have you moved in the last two years? | Yes | No |
| 12) Do you find it hard to talk about personal problems with other people? | Yes | No |
| 13) Do you have problems in your relationships with other people? | Yes | No |
| 14) Do you prefer not to participate in community or social activities? | Yes | No |
| 15) Have you changed jobs/schools in the last two years? | Yes | No |
| 16) Do you hate going to work/school? | Yes | No |
| 17) Do you have a legal problem? | Yes | No |
| 18) Are you experiencing financial problems? | Yes | No |
| 19) Have you lost hope that your problem can be resolved? | Yes | No |
| 20) Have you lost motivation to work on your problem? | Yes | No |