

Client Intake Survey
The Clarity Psychological Group, LLC.
3915 Cascade Road Suite 250
Atlanta, Georgia 30331

Name: _____ Date: _____ Birthday _____ Age: _____

How were you referred to us?

- Primary Care Doctor
- Inpatient Hospital
- Friend or Family
- Psychology Today
- Facebook
- Other: _____

What type(s) of counseling are you seeking?

- Individual
- Couples
- Family

Have you ever participated in counseling before?

- Yes
- No

If yes...

When was your last session? _____

Please list the name of your previous therapist: _____

What was the purpose of your treatment? _____

Have you ever received any psychiatric treatment?

- Yes
- No

Have you ever received drug or alcohol treatment?

- Yes
- No

Have you ever been hospitalized for mental health concerns?

- Yes
- No

Please describe your sleep patterns including the number of hours that you sleep each night:

Please describe your eating habits:

Have your eating habits changed over the last 6 months? If so, in what way?

If you answered yes to any other the previous questions, please explain below:

Please provide your current and past medical history below:

Medical Diagnosis/Issues	Current Treatment/ Medicine

Please list all medications, vitamins and supplements that you are currently taking:

Medication/ Drug	Dose	Frequency	Reason for taking/ Response to medication

List any drug allergies or adverse medical reactions:

Please indicate with a (√) if you have used or currently use the following substances.

Drug of Choice	Current/Previous Use	Frequency of Use
Alcohol		
Drugs		
Tobacco		
OTC		
Other		

In the past month, has anyone complained to you about your drinking?

- Y
- N

Have you ever thought that you may need to change your drinking habits?

- Y
- N

Do you ever have trouble remembering how much you've had to drink?

- Y
- N

Family of Origin

Relative	Name	Current age (or age at death)	Physical and/or Mental Health Illnesses (cause of death if deceased)	Relationship (excellent, good, fair, poor)
Mother				
Father				
Brothers and Sisters				
Others: (step parents or siblings, grandparents, etc.)				

Describe the emotional atmosphere in your childhood home:

Education:

Did you graduate from high school or receive a GED?

- Yes
- No

If yes, where did you attend? _____

Did you graduate from college or technical school?

- Yes
- No

If yes, where did you attend? _____

Did you attend any graduate school?

- Yes
- No

If yes, where did you attend? _____

Do you have any special skills or trades? If yes, what are they?

Employment:

Current Employer: _____

- FT
- PT

Current issues with work?

- Yes
- No

If yes, please explain:

Are you applying for/intend on applying for disability or workman's compensation?

- Yes
- No

If yes, please explain:

Stress level at work

- Low
- Medium
- High

How long have you been with your current employer?

- 0-6 months
- 6 months-1 year
- 1-5 years
- 5-10 years
- Over 10 years

Are you experiencing any legal issues?

- Yes
- No

Are you experiencing any financial issues?

- Yes
- No

Military experience and/or combat experience

- Yes
- No

Social Information

Please indicate your current marital/relationship status:

- Married
- Single
- Separated
- Divorced
- Widowed
- Living with partner

Do you have children?

- Yes
- No

If yes, please note first names and ages below:

Describe the relationship with your spouse/partner?

What are the strengths of your relationship? What are the weaknesses?

What would you like your therapist to know as she develops your treatment plan?

Thank you for completing intake form. Please return completed packet to the front desk.