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 If yes, where did you attend? _____
- ☐ No

Did you graduate from college or technical school?

- ☐ Yes If yes, where did you attend? _____
- ☐ No

Did you attend any graduate school?

- ☐ Yes If yes, where did you attend? _____
- ☐ No

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.