

PO Box 763 280 Main Street, Suite 14 Hill City, SD 57745 Office: 605.390.8791

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Client Intake Form

Name:

A. Religious,	ethnic, and gender ident	ification	
Current relig	ious denomination/affilia	tion if any (specify):	
Involvement	t: 🗅 None 🗅 Some/irregu	ılar 🖵 Active	
How importa	ant are spiritual concerns	in your life?	
Ethnicity/na	tional origin or other sim	ilar way you identify yourself and cor	isider important:
What gende	r do you identify with?		
B. Your edu	cation and training		
Dates	Schools	Special classes?	Did you graduate?

C. Employment and military experiences

Dates Name of e	mployers	Job title or dut	ies	Reason for leaving
Dutes Nume of C	Inployers	JOD LILIC OF UUL	103	incusori for icuving

D. Legal History

Dates Convictions Incarcerations Probation or Parole status

E. Family-of-origin History

<u>Relative</u>	Name	Age (or age at death if deceased)	Education	Occupation
Parent/Guardia	n			
Parent/Guardia	n			
Siblings				
Stepparents				
Grandparents				

F. Marital/life partner/relationship history

G. Children

Name	Current age	Gender	School Grade

H. Health Status

Chronic/serious Illnesses

I. Substance use history:

Substance	How often	How much	Date of last use

J. Chief concern: Please describe the main concern(s) that has brought you to see me.

K. Treatment

1. Have you ever received psychological, psychiatric, drug or alcohol treatment, or counseling services before?

No
Yes If yes, please indicate:

When?	From whom?	For what?	With what results?

2. Have you ever taken medications for psychiatric or emotional concerns?
No Yes If yes, please indicate:

When? From whom? Which medications? For what? With what results?

L. Self-harm history: (cutting, suicide attempts, risky behaviors)

M. Trauma - Any Other Information

N. Goals for Counseling

This is a strictly confidential patient medical record. Re-disclosure or transfer is expressly prohibited by law.