



37875 W. 12 Mile Rd. Suite 204
Farmington Hills, MI 48331
(248) 798-4402
(248) 910-1591
(248) 703-2578

CLIENT INTAKE FORM

Name: _____ Age: _____

Birthdate: _____ Phone Numbers: Home: _____ Work: _____

Cell Phone: _____ Best time to reach you: _____

Other Family Members Attending: _____

Address: _____

Residence (circle): Own Home Apartment Live With Parents Dorm Other _____

Current Marital Status (circle): Single Engaged Married Remarried Separated
Divorced Widowed Living Together Gay/Lesbian Relationship

Length of Time in this Marital Status _____

Spouse/Significant Other's Name _____ Age: _____

Have you had any previous marriages? _____ From _____ to _____

Current Household Members: List all persons with whom you currently live. Please include their name, sex, age, and relationship to you (spouse, significant other, child, parent, sibling, etc.). Put an asterisk * next to any person you currently have a concern about.

Overall impression of your present family life: _____



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Present Occupation: _____ Length of time: _____

Employer: _____ Job Satisfaction: _____

Father's Name _____ Age: _____

If deceased, date of death _____

Mother's Name _____ Age: _____

If deceased, date of death _____

Siblings: Please list the name, sex, and age of all your brothers and sisters.

Overall impression of your childhood family life: _____

What is the highest level of education you have completed? _____

Are you planning any further education? _____ If so, please specify _____

Describe if and how religion/spirituality plays a part in your life: _____

List activities that you enjoy: _____

What do you see as your strengths? _____

What do you see as your weaknesses? _____

What are your main fears? _____



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What are your major life goals at this time? _____

Do you or any member of your family suffer from alcohol or substance abuse? _____

If yes, please describe: _____

Do you or any member of your family have a history of mental illness? _____

If yes, please describe: _____

List any serious illnesses, accidents, operations, or traumatic experiences (such as physical or sexual abuse) you have ever had and your age at the time: _____

Date of last physical exam? _____ Findings: _____

Are you being seen by any other professional person (physician, minister, priest, rabbi, psychologist, social worker, etc.) for physical or emotional difficulties at this time? _____

If yes, please describe the nature of the problems and their treatments: _____

Why did you decide to enter counseling at this time? _____

Have you had previous counseling? _____ If yes, approximately when? _____

How many times did you see this counselor? _____



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Was it a beneficial counseling experience? _____ Please explain: _____

How will you measure the success or failure of your counseling experience with Lifestart Counseling? _____

Is there any other information not previously covered which would be important for the counselor to know? _____

How did you find out about Lifestart Counseling? _____

In case of an emergency, contact _____

Relationship _____ Phone _____

Client Signature _____ Date _____

I have reviewed the contents of this form and have discussed the same with the client.

Therapist _____ Date _____