Wellspring Inc.
Client Intake Information

Patient's Name____________________________ Age_____ Sex: M F Marital Status___________

Occupation__________________________ Education_________ Primary Care Physician______________

Other living in home_________________________Emergency Contact____________ Phone___________

Please describe reason(s) for seeking counseling____

Please indicate significant concerns by marking the corresponding line: (leave blank if symptoms do not apply.

Completed by Client:

Eating Habits
Appetite + or - _____
Binge_____
Purge_____
Weight______

Sleeping Trouble

Trouble falling asleep______
Staying asleep______
Trouble waking up______
Average # hours of sleep_______
Number of naps______

Decreased energy/Fatigue________
Sexual functioning_________
Lost of interest in activities_________
Tearfulness________
Hopelessness_______
Helplessness________
Decreased attention span________
Inattentive/Distractible__________

Memory
Long term______
Short term______
Difficulty planning ahead_______
Oppositional_______
Anger Outbursts_______
Difficulty controlling actions________
Mood Changes_______
Anxious/Nervous________
Worry/Fear_______
Stealing________
Lying________
Truancy______
Fire Setting______

Completed by Therapist

History/Goals/Interventions

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Completed By Client

Police Problems__________
Probation_______
Spending sprees________
Rapid Heartbeat________
Phobia (s)____________
Sweating_________
Trouble Breathing________
Flashback of traumatic events________
Nightmares_______
Racing Thoughts______
Hearing Voices_______
Seeing thins that are not there_______

Coffee # cups/day_________
Cigarettes# per day________
Alcohol 3 drinks per day________ week_______
Date of last drink_________________
Street Drugs:
Type______________________
Amount___________________
Frequency_________________
Date last used_______________

Prescription Drugs:
Type__________________________
Amount________________________
Date last used___________________

Describe impact of substance abuse on your life

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____
____

Past treatment for substance abuse

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____
____

Family History of substance Abuse

____
____
____

____

Patient or legal representative signature **Date**

Completed By Client

Past Treatment History

Psychiatric or psychological treatment of any kind before?

Yes__________ No__________

If yes please answer the following

What type of care was received?
Impatient________ Outpatient________ Both________

When was the treatment?______________________
Where was the treatment?______________________
How long was the treatment?___________________
Who was the therapist or Doctor?__________________

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Was there prescribed medication?

Yes________ No_________
If yes what was the prescribed medication?

Medication______________ Dosage___________
Medication______________ Dosage___________

Family History of psychiatric treatment include those currently in treatment:
____
____

Allergies?____

Chronic illness or other medical condition:____________________________
____
____

Treating Physician for chronic conditions:

_____________________________ phone #___________________________
_____________________________ phone#___________________________

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Patient/legal representative Signature Date