

CLIENT PERSONAL DEMOGRAPHICS AND INTAKE QUESTIONNAIRE

Virginia Compton, MS, LMHC

Beachside Counseling and Wellness, LLC

122 4th Ave, Suite 200

Indialantic, FL 32903

321-327-3793

Client Information

Today's Date _____

Client's First Name: _____

Middle Initials: _____

Client's Last Name: _____

Preferred Name _____

Client Birthday _____

Client's Sex Assigned at Birth _____

Client's Gender Identity _____

Client's Sexual Orientation _____

Client's Preferred Pronouns _____

Client's Cultural Identity (race and/or ethnicity) _____

Client's Marital Status: Single ____ Married ____ Partner ____ Separated ____ Divorced ____ Widowed ____

Client's Address

City _____ State _____ Zip _____

Birthplace (City/State/Country) _____

Home Phone _____ Cell Phone _____ Work Phone _____

May we leave a message at the listed phone number(s)? Yes ____ No ____

If yes, which phone number? _____ (Or please circle the best number to leave a message)

Would you like reminder messages via text? Yes ____ No ____

Client's Email _____

Referred by _____

May I thank this individual for the referral? Yes ____ No ____

Responsible party information (IF OTHER THAN CLIENT) or Guardian (IF CLIENT IS A MINOR):

Relationship to client _____

First Name _____ MI _____ Last Name _____

Address _____

City _____ State _____ Zip _____

[illegible]

Client's Occupational Information

Client's Employment Status:

Employed Full-Time ____ Employed Part-Time ____

Unemployed/Other ____ Retired ____

Student Full-Time ____ Student Part-Time ____

Client's Military/Service Status:

N/A ____ Active Duty ____ Reserves ____

Military Spouse ____ Military Dependent ____

Client's Employer _____ **Employer's Phone** _____

Address _____

City _____ State _____ Zip _____

Highest level of education completed _____

IF CLIENT IS A MINOR: What school does the client attend? _____

What grade is the client in? _____

Emergency Contact Information

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Primary Care Physician _____ **Phone** _____

Psychiatrist _____ **Phone** _____

Other physician(s) relevant to your care (Please list their specialty and name):

_____ **Phone** _____

_____ **Phone** _____

Does Beachside Counseling and Wellness, LLC and/or Virginia Compton, LMHC, have your permission to share your records with your Primary Care Physician and your Psychiatrist, if your Primary Care Physician and/or Psychiatrist requests your records? If yes, please sign:

Client's signature

Date

Parent/guardian signature (if client is a minor)

Date

Current Medications (please list all: prescribed, over-the-counter, homeopathic/vitamins/supplements):

Name of medication	Dosage	Frequency	Start date	Prescribing physician

Hospitalizations: Please list reasons and approximate dates of any hospitalizations

Please list any allergies or medical concerns (including pregnancy):

Current or Past Stressors or Problems with:

Occupation/Career

Marriage/Relationship

Legal System

Finances

Parenting

Social Life (Isolation, Conflict, Etc)

Medical/Health Concerns

Chronic Pain

Loss of a Loved One

Physical or Sexual Abuse

Emotional or Verbal Abuse

Risky Activity

Please mark items in the following list with “Hx” if you have a history of these symptoms, and “PR” if you are presently experiencing them:

- | | | |
|---|---|---|
| ☐ Anger Problems | ☐ Crying Spells | ☐ Change in Appetite |
| ☐ Computer Addiction | ☐ Head Injury | ☐ Disturbed Body Image |
| ☐ Thyroid Problems | ☐ Unhappiness | ☐ Memory Problems |
| ☐ Dizziness or Fainting | ☐ Digestive Problems | ☐ Numbness |
| ☐ Seizures | ☐ Pounding Heart | ☐ Depression |
| ☐ Headaches | ☐ Muscle Tension | ☐ Guilt / Shame |
| ☐ Migraines | ☐ Weight Problems | ☐ Racing Thoughts |
| ☐ Nightmares | ☐ Low Energy | ☐ Binge Eating |
| ☐ Trouble falling/staying asleep | ☐ Excess Energy | ☐ Blackouts |
| ☐ Heavy drinking | ☐ Panic Attacks | ☐ Phobia(s) |
| ☐ Drug Abuse | ☐ Mood Swings | ☐ Fatigue |
| ☐ Trouble / Pain Urinating | ☐ Anxiety | ☐ Libido Changes |
| ☐ Feelings of inadequacy | ☐ Chest Pain | ☐ Impulsivity |
| ☐ Cold Hands and Feet | ☐ Purging | ☐ Sexual Issues |
| ☐ Unpleasant Ideas Stay in Head | ☐ Hallucinations | ☐ Other |
| ☐ Avoidance | ☐ Loss of Interest in Daily Activities | |

☐ Suicidal thoughts – if yes, please state what they sound like, how often they occur, and how long they last: _____

☐ Suicide Attempt – if yes, please list date(s): _____

☐ Self-harm behavior (including cutting, burning, scratching, head banging)

Developmental and Social Details

Who raised you? Where did you grow up?

Does anyone in your family have a history of mental illness or psychiatric issues? If yes, please list who, their relationship to the client, their diagnosis, and treatment:

Does anyone in your family have any substantial medical conditions or chronic illness? If yes, please list who, their relationship to the client, their diagnosis, and treatment:

What hobbies or activities does the client currently enjoy or would like to explore?

What is your current daily usage of electronics (TV, cell phone, video games, tablet)?

Exercise type and frequency?

Is there anything you would like to share about the client's relational journey (adoption, divorces, LGBTQ, etc)?

Are you aware of any verbal, physical, emotional or sexual abuse in your family? If yes, please note who/type as you are comfortable:

Has the client ever experienced or witness any verbal, physical, emotional or sexual abuse? If yes, please note who/type as you are comfortable:

Is the client currently still experiencing or witnessing any verbal, physical, emotional or sexual abuse that was previously explained?

Was there anything abnormal about the client's birth (premature, complications, parent used illicit drugs, parent took prescription medication(s), etc)?

Were there any abnormal developmental milestones (delayed walk or speech, potty training struggles, etc)?

Did the client receive any speech, occupational, or physical therapy? If yes, please specify:

Does the client have any special services in school (such as a 504 plan or IEP/Special Education Plan)?

Does the client experience developmental delays in any of the following areas?

____ Speech/Language ____ Occupational/Fine Motor Skills ____ Physical/Gross Motor Skills

____ Vision ____ Hearing

Have you ever been to therapy before? If so, please list approximate dates. What went well and what didn't go well? IF CLIENT IS A MINOR, are parents/guardians also engaged in their own therapy?

Client's Substance Use History

*****Clients under age 12 – parents/guardians, please use your discretion in collaborating with your child on the completion of the substance use history chart on this page*****

	Ever Used? (Y/N)	Used in Last 3 Months? (Y/N)	Route (smoked, ingested, IV)	Amount and Frequency	Date of Last Use	Prescribed? (Y/N)
Tobacco						
Alcohol						
Caffeine						
Marijuana/THC						
Amphetamines (Ritalin, Adderall, etc)						
Methamphetamine						
Cocaine						
Ecstasy (MDMA)						
Benzodiazepines (Xanax, Klonopin, etc)						
Barbituates (phenobarbital, etc)						
Heroin						
Opioids (Hydro/Oxycodone, Fentanyl, etc)						
Inhalants (Nitrous, Huffing, etc)						
Bath Salts						
Ketamine						
LSD/Hallucinogens						
K2						

Please list any substance use treatment you have engaged in, how it went, and associated dates:

ONLY COMPLETE THE FOLLOWING ASSESSMENTS IF YOU ARE 12 YEARS OLD OR OLDER

GENERALIZED ANXIETY DISORDER-7

Over the last 2 weeks, how often have you been bothered by any of the following problems?
Please circle your answers.

GAD-7	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all

Somewhat difficult

Very Difficult

Extremely Difficult

PATIENT HEALTH QUESTIONNAIRE-9

Over the last 2 weeks, how often have you been bothered by any of the following problems?
Please circle your answers.

PHQ-9	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3

4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, like reading the newspaper or watching tv	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed, or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all

Somewhat difficult

Very Difficult

Extremely Difficult

Suicide Risk Screening

For clients ages 12 and older, please complete the following standard suicide/risk assessment questions. Completing this assessment will not initiate a crisis response. This assessment will be used during your first appointment to help facilitate treatment planning and will not be reviewed by the front desk prior to your first visit. If you are currently experiencing thoughts of suicide, you can contact the National Suicide & Crisis Lifeline 24/7 by calling or texting 988. If you are currently having suicidal intent, plan, or method in mind, please immediately call 911 or go to your nearest emergency room.

In the past few weeks, have you wished you were dead? ____ Yes ____ No

In the past few weeks, have you felt that you or your family would be better off if you were dead?
____ Yes ____ No

In the past week, have you been having thoughts about killing yourself? ____ Yes ____ No

Have you ever tried to kill yourself? ____ Yes ____ No

Are you having thoughts of killing yourself right now? ____ Yes ____ No

Any other information that might be helpful to your treatment:
