The Center for Counseling, Growth, and Development
at Jewish Family Services of Greater Orlando

CLIENT INTAKE HISTORY

Please complete the following information prior to your first appointment. This will help us learn more about you during your first visit.

Client Name: ____ Date: _______________________

Relationship Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other: ________________

How long have you been in this relationship? ____

Other significant relationships: ____

____

Highest level of education: ☐ Elementary/Middle School ☐ High School ☐ Trade School

☐ College ☐ Advanced Degree/Professional: ____________________

Describe your childhood and upbringing: ____

____

____

Describe your current family relations: ____

____

____

Describe any history of abuse: (*check all that apply)*

☐ Physical: By Whom? ____________________ How old were you? ______________________________

☐ Emotional:By Whom? ___________________ How old were you? ______________________________

☐ Neglect: By Whom? ____________________ How old were you? ______________________________

☐ Sexual: By Whom? _____________________ How old were you? ______________________________

Additional information: ____

____

____

History of substance abuse: *(include age when started and last use)*: _____________________________

____

____

Counseling history: *(please include psychiatric, support groups, substance abuse treatment)*: __________

____

____

Medical problems: ____

____

____

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Medication	**Dosage**	**Reason for Use**	**Prescribing Doctor**

Who is your support system? ____

____

____

What do you hope to gain from counseling (goals)? ______________________________

____

____

____ ______________________
Signature of Person Completing Form Relationship to client (if other than self)

For therapist's use only:

Therapist's Notes:

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