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

Chart #: ________

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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Chart #: ________

Client Name:____ Date: _________________________

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:

Rev 12/14