Beau Dantin, LPC
Baton Rouge Counseling Associates
10935 Perkins Road, Suite B
Baton Rouge, LA 70810

Individual Intake Form

Client Name_____ **Date of Birth**_____ **Age**_____

Responsible Party _____ **Date of Birth**_____ **Age**_____

Physical Address_____ **City**_____ **State**_____ **Zip**_____

Mailing Address (if different from physical address) _____

City_____ **State**_____ **Zip** _____ **E-mail**_____

Home Phone_____ **Work Phone**_____ **Cell / Other**_____

Social Security Number_____/_____/_____ **Birthplace**_____

Place of Employment_____ **Occupation**_____

Last Grade Completed____ **High School Diploma/GED** ❑ **College Degree** ❑ **Graduate Degree** ❑

Marital Status (indicate # of yrs): ❑ Married_____ ❑ Divorced_____ ❑ Widowed_____
❑ Separated_____ ❑ Engaged_____ ❑ Cohabitating_____ ❑ Single

Spouse's Name_____ **Date of Birth**_____ **Age**_____

Spouse's Place of Employment_____ **Work Phone**_____

List all others living in your home and their relationship to you:

Names	Age	Relationship	Occupation	Employment

Problem/Symptom Checklist

❑ Alcohol / Drugs	❑ Family	❑ Marriage	❑ Singleness
❑ Aging	❑ Fear	❑ Money/Budgeting	❑ Smoking
❑ Anger	❑ Finances	❑ Mood Swings	❑ Stress Management
❑ Anxiety	❑ God / Faith	❑ Other Addiction	❑ Trauma
❑ Co-Dependency	❑ Grief / Loss	❑ Parenting	❑ Violence
❑ Child Custody	❑ Guilt	❑ Past Hurts	❑ Weight Control
❑ Communication	❑ Hopelessness	❑ Premarital	❑ Work / Career
❑ Depression	❑ Intimacy	❑ School / Learning	❑ Other_____
❑ Disabled	❑ In-laws	❑ Self-Esteem	❑ Other_____
❑ Divorce/Separation	❑ Loneliness	❑ Sexual Issues	❑ Other_____

Have you ever seen a counselor/pychiatrist before? Y / N
If yes, who & when:

_____
_____
_____

History of the Presenting Problem or Complaint
State the nature of your problem: _____
_____
_____
_____
What do you want to accomplish during your sessions? _____
_____
_____
Who is coming for counseling?_____
What is your most difficult relationship right now?_____
What is your most difficult emotion right now?_____
How did you hear about us?_____

Medical History
Any hospitalizations within the last five (5) years;_____
Have you ever received psychiatric help before? ❑Yes ❑ No
If yes, explain:

_____
_____

Rate Your Physical Health: ❑ Very Good ❑ Good ❑ Average ❑ Declining ❑ Poor
Recent Weight Changes: *Gained*_____*Lost*_____
Check if Applicable: ❑ Difficulty Sleeping ❑ Difficulty Eating ❑ Headaches
How many hours of sleep do you average each night? _____

Current Medical Conditions (ex. high blood pressure, asthma, chronic pain, etc.):

_____
_____

Please list any medications you are <u>currently</u> taking even if they were not prescribed for you:
Name Dosage / How Often Reason Taken How Long Taken Repsonse / Side Effects

_____
_____
_____
_____

Please list any medications that you have <u>previously</u> taken for anxiety, nervousness, depression, or related types of problems.

Name Dosage / How Often Reason Taken How Long Taken Repsonse / Side Effects

_____

_____

_____

Caffeine Usage: Please specify the amount of any of the following products <u>with caffeine</u> that you drink or use within a typical 24 hour day.

Cola Beverage_____ Brewed Coffee_____ Instant Coffee_____
Instant Tea_____ Brewed Tea_____ Caffeine Pill_____
Chocolate Beverage_____ Chocolate Candy_____ Other_____

Religious Affiliation:_____
Meaningfullness of religion in your life? Low Moderate High (circle one)

Crisis Information:

Any current suicidal thoughts, feelings, or actions? ❑ Yes ❑ No
Any current homicidal thoughts, feelings, or actions: ❑ Yes ❑ No
Do you have a history of anger of impulse control problems? ❑ Yes ❑ No
Have you experienced the death of a loved one within the last five (5) years? ❑ Yes ❑ No
Have you experienced any other significant losses within the last five (5) years? ❑ Yes ❑ No
If yes, please explain_____
Have you ever been arrested? ❑ Yes ❑ No If yes, please explain_____
_____
Have you ever served time in jail? ❑ Yes ❑ No If yes, please explain_____
_____
Do you currently use any illegal drugs or other substances including marijuana? ❑ Yes ❑ No
Have you ever used any illegal drugs or other substances including marijuana? ❑ Yes ❑ No
Do you smoke or use tobacco products? ❑ Yes ❑ No
Do you drink alcoholic beverages including beer, wine, or liquor? ❑ Yes ❑ No

Marriage Information:

Is your spouse willing to come to counseling? ❑ Yes ❑ No
Have you ever been separated? ❑ Yes ❑ No
Have either of you ever filed for divorce? ❑ Yes ❑ No
Date of Marriage_____ Your ages when married: Husband_____ Wife_____
How long did you know your spouse before marriage?_____
How long did you date your spouse?_____
How long were you engaged?_____

Have any of your family members ever received psychiatric or psychological help or counseling of any kind before? ❑ Yes ❑ No
If yes, please explain:

_____

_____

_____

Do any of your family members have a history of mental illness? ❑ Yes ❑ No If yes, please explain whom and the nature of the illness._____

_____

Client Signature:____ _____ _

Parents Signature if client is a minor:_____

Date:_____