Bruce Deveau, LICSW
Client Profile / Intake Form

Client Name ____ Home Tel. ____________________________

Work or Cell________________________ Street Address____

City___________________________________ State_______ Zip___________________

Date of Birth____/____/____ Sex_____ Social Security #_____________________ Marital Status__________

Employment: ____Full Time ____Part Time ____Self Employed ____Not Currently Employed

Employer Name ____

Address____Phone_________________

Student ____No ____Yes ____Full-Time Student ____Part-Time Student

Referred by: Name________________________Credentials________

Primary Care Physician_____________________________________Tel._____________________

Person(s) Responsible for Payment: Same as above _____Yes ____No If No:

Name____ Home Tel.____________________________

Work or Cell: _____________________ Street Address____

City______________________________State_____Zip_____________

Primary Health Insurance: ____________________________ Effective Date___/___/___

Policy / ID # ____________________________Cert. #___________________Group name / #_____________

Policy Holder: Same as above _____Yes ____No If No:

Name______________________ Address____

Policy Holder's Phone_________________Date of Birth___/___/___ Social Security #____________________

Policy Holder's Relationship to Client: (circle) Self Spouse Child Other:_____________

Policy Holder's Employer: ____

Other Insurance ____

For Office Use

Clinician: __________________________Date: ___/___/___ Date first seeing this client: ___/___/___

Dx: Axis I_________/_________ Axis II________ Axis III___________ Axis IV____________GAF____

Mental Health Benefit authorized by: (MCO Name):_____________________________Date: ___/___/___

Deductable: _______________Benefit Max: _______________________Copayment: _________________

# of sessions authorized: ______Beginning date: ___/___/___ through: ___/___/___ Auth. #______________

Clinician ID for this payor:______________________ Other: _____________________________________

Background Information

Your answers to these questions will help me understand you better and help us get to work more quickly.
If you'd rather answer certain questions in person, just leave them blank.
If you need more space you can use the back side of the page.

Problem Description		
Please describe the problem or problems that bring you in for counseling.	How long have you been dealing with this problem?	Distress level on a scale of 1 – 10, with 10 being the worst.

Family and Relationships						
Relationship	**Name**	**Age**	**Living**		**Living with you**	
			Yes	**No**	**Yes**	**No**
Mother						
Father						
Spouse/partner						
Children						
Were you adopted? ___Yes ___No Raised in foster care? ___Yes ___No						
Other significant relationships						

Relationship Status (Please check all that apply)

___Single ___Married ___Unmarried, living together ___Separated ___Divorced ___Other__________

Sexual Orientation: ___Straight ___Bisexual ___Gay/Lesbian ___Transgender ___Questioning

Assessment of current primary relationship (if applies) ___Good ___Fair ___Poor ___ Very Troubled

Special Circumstances (Alternative or blended families, in-laws, etc.)_________________________________

____

Physical Health

Please describe significant physical disorders you are experiencing now or have in the past:

____
____
____
____

Nutrition

Diet: How many meals do you typically eat in a day?______________________________________

Nutrition: ___Very healthy foods ___Moderately healthy foods ___Unhealthy foods

Any recent changes in appetite or weight: ____

History of eating disorder? ___Yes ___No ____

Comments:____

Medications

Current Prescribed Medications	Dose	Purpose

Allergies:____

General Health Concerns

Date of last physical exam: ___/___/___ Results: ______________________________________

Date of last doctor's visit: ___/___/___ Results: ______________________________________

Date of last dental exam: ___/___/___ Results: ____

Recent changes in overall health? (eg: energy level, behavior, sexual problems): ________________

____

Family history of mental illness? ____

____

Sleep

Do you have any trouble with sleep?___Yes ___No Do you experience daytime sleepiness?___Yes ___No

How many hours do you sleep most nights?____ How long does it normally take to fall asleep?_______

If you wake in the middle of the night, how long does it take to fall back asleep?__________________

Comments: ____

Development

Are there unusual, traumatic or abusive events that occurred when you were growing up? ___Yes ___No

If yes, what kinds of events? ___Physical ___Sexual ___Verbal/Emotional ___Accident or devastating loss

Comments: ____

____

Safety Concerns

Do you now (or have you in the past) have safety concerns for yourself or others? This includes suicide, domestic violence, and any self harm or threatening behavior. ___Yes ___No (if yes, check all that apply)

	Type of harming behavior	**Intensity on a scale of 1--10**
	Occasional fleeting thought without plan	
	Occasional thought with plan considered	
	Frequent thought with plan	
	Frequent thought with plan and action (such as cutting or purchasing a weapon)	
	I have attempted to harm myself or others. Explain:____	
	I have other safety concerns. Explain: ____	
	I have been a witness to or victim of violence, trauma, domestic violence, rape or assault. ____	
	I am in danger of becoming a victim of domestic violence.	

Social, Cultural, Spiritual

How would you describe yourself in social relationships? Please check all that apply.

___ Easy, friendly ___ I'm a leader ___Avoidant ___Outgoing ___Victimized

___Follower ___Argue often ___Affectionate ___Loner ___Caretaker

___Assertive ___Explosive ___Passive ___Aggressive ___Withdrawn

Are there certain people with whom you are especially comfortable? ______________________________

Are there certain people with whom you are especially uncomfortable? ____________________________

Other comments:____

Cultural/Ethnic

To which cultural/ethnic group do you belong? ____

Are you experiencing any problems or discrimination due to cultural or ethnic issues?_____________________

____

Spiritual/Religious

How important are spiritual matters to you? ___Not ___Some ___Very Much ___Questioning

Are you affiliated with a spiritual or religious group? ___Yes ___No ____________________________________

Were you raised within a spiritual or religious tradition? ___Yes ___No _______________________________

Would you like spiritual or religious beliefs incorporated into your treatment? ___Yes ___No

Comments: ____

Legal Issues

Current Status: Are you involved in any active legal cases? If so, please comment: ________________________

____

Are you presently on probation or parole? ___Yes ___No Part of a restraining order? ___Yes ___No

If yes, please comment: ____

____

Past History: Please check all that apply

Traffic violations ___Yes ___No DWI, DUI, etc. ___Yes ___No

Criminal involvement ___Yes ___No Civil involvement ___Yes ___No

If yes to any above, please describe: ____

____

____

Educational

Fill in all that apply: Currently a student ___Yes ___No

___High school/GED Graduated ___Yes ___No Area of interest: ________________________________

___Tech or Voc. Graduated ___Yes ___No Specialty:________________________________

___College Graduated ___Yes ___No Major:________________________________

___Graduate Graduated ___Yes ___No Major:________________________________

Other comments (training, learning disabilities, talents, etc.) ____

____

Employment

Current work status: ___Employed ___Fulltime ___Part time ___Temp ___Unofficial or under-the-table

___Unemployed ___Laid off ___Disabled ___Seeking work ___Given up

Please briefly describe work history: ____

____

Military

Military experience ___Yes ___No Combat experience ___Yes ___No Where?____________________

Branch___________________ Please describe your experience: ________________________________

____

Leisure/Recreation

Please describe special areas of interest or hobbies, including recent and past activities:

____

Substance Use / Addiction History				
Kind of substance	**Amount used**	**Frequency of use**	**Age at first use**	**Most recently used when**
Alcohol				
Barbiturates				
Benzodiazepines				
Cocaine/Crack				
Heroin/Opiates				
Marijuana				
PCP/Hallucinogens				
Inhalants				
Caffeine				
Nicotine				
Over the counter				
Prescription drugs				
Others				

Substance of choice:

____ ____

How have drugs or alcohol been associated with problems in your life? Please explain:

____

Are there behaviors or compulsions that feel out of control or create problems in your life? For example, excessive shopping, gambling, internet use, sexual obsessions, food, etc.? If yes, please explain:

____

Prior Counseling / Treatment		
Have you been in counseling or other mental health treatment in the past? If yes, please describe.		
Type of treatment or purpose	**When**	**Outcome or experience**

Strengths and Experience	
Each person is different, so these questions are important in helping me understand what works for you. Please answer the following questions to the best of your ability:	
What personal strengths do you have that will help us in solving the problem that brings you into counseling?	
What supports do you have or could access that might be helpful?	
What have you tried to help the problem so far? What worked, even a little?	
What have you tried before and didn't work? What should we learn from that?	
What do you imagine my role will be in helping you?	
What do you imagine will be the first sign that our work is being successful?	
What are you hoping to achieve in coming in to work together?	
What will be a sign that you no longer need to come in anymore?	

Obstacles and Stressors	
What stressor or obstacles besides the identified problem might get in your way? Please describe.	
Financial Stress	
Social stress, isolation, disconnection	
Other stressors	