Delta Counseling
3701 Lone Tree Way
Antioch, California 94509
(925)864-4042

Intake Form

1. Client Name_____Birth date_____Age_____
   First Full Middle Last

   Spouse/partner Name_____Birth date_____Age_____
2. Address_____City_____Zip Code_____
3. Home Phone ( )_____ ( )Work Phone_____

4. Occupation_____Employed by_____
   a. May we say who we are if we phone your home? [ ] Yes [ ] No
   b. May we call you at work? [ ] Yes [ ] No

   If minor- School_____ Teacher_____ Grade_____

5. Martial Status: (circle) Married Single Divorced Widowed Separated: Length of time_____

6. If Patient is a minor, Name of Responsible Adult_____

7. Name of Closest relative(emergency contact)_____
   Phone ( )_____

   a. Address_____City_____Zip Code_____

8. Have you had previous therapy? [ ] Yes [ ] No
   a. If yes, with who?_____Start Date____End Date____
   b. Type of therapy? [ ] Family [ ] Individual [ ]Group [ ]Other

9. How did you hear about this practice?_____

Please fill out completely

PRESENTING PROBLEM:

MEDICAL HX:

Primary Care Provider _____ Last Physical Exam ___/___/___ Last Dental Exam ___/___/___

Do you have, or have you ever experienced any of the following (include childhood diseases/injuries)?

☐ High Blood Pressure	☐ STD	☐ Heart Problems	☐ Hepatitis/Liver	☐ Sleep Problems	☐ Surgeries
☐ Loss of Consciousness	☐ TB	☐ Urinary Problems	☐ Diabetes	☐ Skin Problems	☐ Asthma
☐ Appetite/Weight Change	☐ Withdrawal Seizures	☐ Thyroid Problems	☐ Pregnancy	☐ Vision Problems	☐ Drug Reactions
☐ Head Injury	☐ Seizures	☐ Kidney Disease	☐ Prosthesis	☐ Hearing Problems	☐ Other: .....

Describe (age/where treated): _____

Allergies:

CURRENT MEDICATIONS (prescribed and over-the-counter):

Name of Medication	Dosage/Frequency	Prescribed by	Date 1st Prescribed	Last Dose
			/ /	/ /
			/ /	/ /
			/ /	/ /
			/ /	/ /

PSYCHIATRIC MEDICATION HX (include relevant responses, and side effects): _____

Compliant: ☐ Yes ☐ No ☐ Unk

SUBSTANCE/ALCOHOL USE (Present = within two weeks)

	Present Y	Present N	Past Y	Past N		Present Y	Present N	Past Y	Past N		Present Y	Present N	Past Y	Past N		Present Y	Present N	Past Y	Past N
Tobacco	☐	☐	☐	☐	Marijuana	☐	☐	☐	☐	Cocaine	☐	☐	☐	☐	Amphetamines	☐	☐	☐	☐
Caffeine	☐	☐	☐	☐	Sedatives	☐	☐	☐	☐	Hallucinogens	☐	☐	☐	☐		☐	☐	☐	☐
Alcohol	☐	☐	☐	☐	Opiates	☐	☐	☐	☐	PCP	☐	☐	☐	☐		☐	☐	☐	☐

Family Members living at home (Include last name if differs from your own)

Name_____Relationship_____Age_____DOB_____

Name_____Relationship_____Age_____DOB_____

Name_____Relationship_____Age_____DOB_____

Name_____Relationship_____Age_____DOB_____

Secondary Residence for Family Members living outside of your home.

Name_____Relationship_____Age_____DOB_____

Address_____City_____Zip Code_____Phone_____

Name_____Relationship_____Age_____DOB_____

Address_____City_____Zip Code_____Phone_____

Have members of your family been assigned a probation officer or social worker?
[ ] Yes [ ] No

Name_____Phone_____

Have you or any member of your family ever received counseling? [ ] Yes [ ] No

Name_____Phone_____

Have you or any member of your family ever been hospitalized for mental health reasons? [ ] Yes [ ] No Dates_____

Name_____Phone_____

Are you or family members now taking any kind of medication? [ ] Yes [ ] No

Type of Medication_____

Have you or any member of your family ever had an alcohol or drug abuse problem?
[ ] Yes [ ] No

Who?_____

For Medical Clients:

Biological Mothers' Maiden Name:_____

Clients Birth Name: _____ County of birth_____

Use (X) for yourself or client (for couples counseling use(√) for spouse/partner)

Current Symptoms:	None	Mild	Moderate	Severe
Depressed mood				
Mood elated				
Mood swings				
Hopelessness				
Suicidal thinking				
Appetite changes				
Significant weight loss				
Disturbed sleep				
Agitation				
Poor concentration				
Obsessive thoughts				
Tense/anxious				
Fearful (Phobic)				
Compulsive behavior				
Fatigue/lethargic				
Overeating/purging				
Violence, antisocial behavior				
Strange behavior				
Strange thoughts				
Self mutilation				
Suicidal				
Homicidal impulses				
Hostility				
Authority conflict				
Long-term memory deficits				
Short-term memory deficits				
Inappropriate speech				
Lawbreaking				
Hallucinations				
Impaired judgment				

Duration of target symptoms: [ ]< 30 days [ ] 1-6 months [ ] 7-12 months [ ] > 1 year