

**Doorways, LLC
Client Intake Form**

Name _____ Date _____ DOB _____ Age _____

School/Work _____

Current Living Arrangements: (City/With Whom) _____

Reason for seeking counseling at this time _____

PRESENTING PROBLEMS:

(Check Symptoms that apply)

- Alcohol or Drug Abuse
- Anger
- Anxiety/Stress
- Compulsive behaviors
- Confusion
- Depression/Sadness
- Fears/Worries
- Hallucinations
- Hopelessness
- Impulses to hurt self or others

- Irritability
- Low Self Esteem
- Medical Physical Complaints
- Memory Difficulties
- Repeated bothersome thoughts
- Sleep Difficulties
- Suicidal Thoughts
- Trouble thinking/Concentrating
- Weight gain or loss
- Other

Family Information:

Family Members	Names	Occupation (Parents/ Spouse)	
Mom			
Dad			
Stepmom			
Stepdad			
Spouse			
Significant Other			
Sibling(s)		Age	
		Age	
		Age	
		Age	

Life Stressors:

- | | |
|--|--|
| <ul style="list-style-type: none"> <input type="checkbox"/> recent losses/deaths <input type="checkbox"/> loss of job(s) <input type="checkbox"/> separation/divorce <input type="checkbox"/> legal problems | <ul style="list-style-type: none"> <input type="checkbox"/> difficult relationships <input type="checkbox"/> financial <input type="checkbox"/> moves/change of school <input type="checkbox"/> abuse/trauma |
|--|--|

Current Medications for Mental Health: _____

