ENVISION
INTEGRATIVE THERAPIES

EAP CLIENT INTAKE
Confidential

Thank you for taking the time to complete this form.
Please include information that you believe is relevant to our working together.

Client Name: _____

Emergency Contact: _____ Relationship:_____

Contact Phone:_____

(If you need additional space, please use the back of this sheet)

Briefly share what precipitated your decision to enter counseling at this time: _____

_____

What problems are you currently experiencing that counseling will help with? _____

_____

What are your goals for change? _____

_____

Previous counseling experience:

Start/ End: _____ Satisfied with results?_____ Completed goals? _____

Number of Children: _____ Ages: _____

Others living with you: _____

_____

If in a relationship, on a scale of 1 – 10, how would you rate your relationship? _____

What significant life changes or stressful events have you experienced recently: _____

_____

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Therapist and Personal Coach
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General Medical History:
Any significant health issues at this time: ☐ yes ☐ no

If yes please list: _____

Your physical health, at this time: ☐ Poor ☐ Fair ☐ Good ☐ Excellent MEDIC ALERT: ☐ yes ☐ no

Are you taking any medications? ☐ yes ☐ no

If so, what_____

General Mental Health:
Are you currently experiencing ☐ sadness ☐ depression ☐ grief? If so: How long? _____

Are you currently experiencing ☐ anxiety☐ panic attacks ☐ phobias? If so: How long? _____

Are you currently experiencing any chronic pain? ☐ yes ☐ no If so: How long? _____

History of suicidal/harm to self: _____

History of psychiatric hospitalizations: _____

Alcohol/ Substance Use:
Describe your use of alcohol:
Occasional: ☐ _____# of times a year. How many drinks: _____
Socially: ☐ _____ # of times per month. How many drinks: _____
Weekly: ☐ _____# of drinks in a week. How many drinks: _____
Daily Use: ☐ _____# of drink per day. How many drinks: _____

Do you use illicit/recreational use of drugs? ☐ no ☐ yes Substance used: _____

Occasional: ☐ _____# of times a year. How much: _____
Socially: ☐ _____ # of times per month. How much: _____
Weekly: ☐ _____# of times in a week. How much: _____
Daily Use: ☐ _____# of times per day. How much: _____

Do you use tobacco products? ☐ yes ☐ no Smoke: ☐ yes ☐ no Chew: ☐ yes ☐ no

Is there anything else you would like me to know? _____

_____