



DR. TEAL BOHRER

Bohrer Counseling and Consulting

Client Intake Form

Name:

Phone:

DOB:

Address:

Emergency Contact:

Relationship to Client:

Phone:

Occupation:

Employer:

Education:

Marital Status:

How did you find Bohrer Counseling and Consulting? And why did you choose Dr. Bohrer?

Describe the issues or problems that bring you into counseling:

When did this begin?

Why counseling now?

What is going well in your life right now?

What are your hobbies and interests?

How are your family relationships?

How are your friendships and/or connections to the community?

What are your goals for counseling?

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Suicidal Ideation	Lifetime		Past 3 months	
1) Have you wished you were dead or wished you could go to sleep and not wake up?	Yes	No	Yes	No
2) Have you actually had any thoughts of killing yourself	Yes	No	Yes	No
3) Have you been thinking about how you might do this?	Yes	No	Yes	No
4) Have you had these thoughts and had some intention of acting on them?	Yes	No	Yes	No
5) Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan? *If "Yes" please explain:	Yes	No	Yes	No

During the first 18 years of your life:

Yes No

Did a parent or other adult in the household often swear at you, insult you, put you down, or humiliate you OR act in a way that made you afraid that you might be physically hurt?		
Did a parent or other adult in the household often push, grab, slap, or throw something at you OR ever hit you so hard that you had marks or were injured?		
Did an adult or person at least 5 years older than you ever touch or fondle you or have you touch their body in a sexual way OR try to or actually have oral, anal, or vaginal sex with you?		
Did you often feel that no one in your family loved you or thought you were important or special OR your family didn't look out for each other, feel close to each other, or support each other?		
Did you often feel that you didn't have enough to eat, had to wear dirty clothes, and had no one to protect you OR your parents were too drunk or high to take care of you or take you to the doctor if you needed it?		
Were your parents ever separated or divorced?		
Was your mother or stepmother: often pushed, grabbed, slapped, or had something thrown at her OR sometimes or often kicked, bitten, hit with a fist, or hit with something hard? OR ever repeatedly hit over at least a few minutes or threatened with a gun or knife?		
Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?		
Was a household member depressed or mentally ill or did a household member attempt suicide?		
Did a household member go to prison?		

Total "Yes" _____