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	g? And why did you choose Dr. Bohi	<u>·er?</u>
Describe the issues or problems that bring you into o	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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Who do you live with?

Name	Age	Relationship	

Hospital History:

Have you ever been to the ho	espital for mental health or addiction issues? Yes No	
When?	Where?	
Why?		
why:		

Counseling History:

Have you had any counseling in the past? Yes	No
Please list any medications you are currently taking:	

<u>Trauma Exposure:</u> (Mark all that apply)

I have been exposed to death, threatened death, actual or threatened serious injury or actual or threatened sexual violence in one of the following ways:

Direct exposure

Witnessing the trauma

Learning that a relative or close friend was exposed to a trauma

Indirect exposure to aversive details of the trauma, usually because of professional duties

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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" _____

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