AXIOM COUNSELING & THERAPY

Date Received

CLIENT INTAKE INFORMATION

Name: _____ Date of Birth: _____

Address: _____ City/State/Zip: _____

Phone: _____ Email: _____

Would you like appointment reminders via text? **YES / NO** via email? **YES / NO**

Employment Status: **Full-Time / Part-Time / Self-Employed / Homemaker / Retired / Unemployed / Student**

Employer or School Name: _____

Emergency Contact Name: _____

Emergency Contact Phone: _____ Relationship: _____

FAMILY INFORMATION

Relationship Status: **Single / Married / Separated / Divorced / Living Together / Widowed**

If married: Spouse's Name: _____ Spouse's Date of Birth: _____

Please list additional family members / residents living in your home:

Name: _____ Sex: _____ Age: _____ Relationship: _____

Name: _____ Sex: _____ Age: _____ Relationship: _____

Name: _____ Sex: _____ Age: _____ Relationship: _____

Name: _____ Sex: _____ Age: _____ Relationship: _____

CLIENT TREATMENT INFORMATION

Why are you seeking counseling/therapy? _____

What are your areas of concern? **(circle all that apply)**

Abuse	Anger Control	Anxiety/ Panic	Career Issues	Chronic Pain	Decision Making
Divorce/Separation	Eating Problems	Fatigue	Fear	Finances	Frustration
Grief / Loss	Health Concerns	Insecurity	Isolation/Loneliness	Lack of Ambition	Lack of Joy
Legal Issues	Memory Loss	Nervousness	Nightmares	Obsessive/Compulsive Behaviors	Parenting Issues
Relationship	Self-Control	Self-Esteem	Shyness	Sleeping Difficulties	Stress
Substance Abuse	Suicidal Thoughts				

CLIENT MEDICAL INFORMATION

Do you have any significant health/medication issues that may hinder the therapeutic process? **YES / NO**

If Yes, please describe: _____

List all medication you are currently taking:

Medication: _____ Dosage: _____ Date Prescribed: _____

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Medication: _____ Dosage: _____ Date Prescribed: _____

Have you noticed any significant changes in the following areas? **(circle all that apply)**

Appetite	Balance	Bowel Movements	Coordination	Energy
Hearing	Memory	Menstrual Cycle	Sexual Activity	Sleeping Habits
Speech	Strength	Thoughts	Vision	