

**Ardent Counseling Center  
CLINICAL INTAKE FORM**

*Please type or print clearly. This sheet must be filled out completely.  
Couples seeking counseling must submit two forms, one per person.*

Client's First name \_\_\_\_\_ Last name \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_  
Best time and number to contact: \_\_\_\_\_  
Alternate number \_\_\_\_\_ Email \_\_\_\_\_  
Birth date \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_ Gender  F  M

Place of Employment \_\_\_\_\_ Length of Employment \_\_\_\_\_  
Salary \_\_\_\_\_ Combined household income \_\_\_\_\_  
Employer/Supervisor name \_\_\_\_\_ Phone \_\_\_\_\_

Name of Spouse/Guardian \_\_\_\_\_ Phone \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_  
Person responsible for payment \_\_\_\_\_ Soc Security # \_\_\_\_\_

Name(s) of Child/Children	DOB	Age
_____	____/____/____	_____
_____	____/____/____	_____
_____	____/____/____	_____

Have you (or spouse) ever been involved in therapy or any other type of counseling program?  Yes  No  
If yes, when: \_\_\_\_\_ Where: \_\_\_\_\_  
Reasons: \_\_\_\_\_

Reasons for considering counseling at this time: \_\_\_\_\_  
\_\_\_\_\_

Are you in treatment with another counselor at this time?  Yes  No  
If yes, with whom: \_\_\_\_\_  
When? \_\_\_\_\_ How long? \_\_\_\_\_

Have you ever been hospitalized for any mental health reasons?  Yes  No  
If yes, when: \_\_\_\_\_  
Where? \_\_\_\_\_

Have you ever, or are you now being treated for any type of chemical dependency abuse?  
 Yes  No If yes, when: \_\_\_\_\_ Length of treatment? \_\_\_\_\_  
Where? \_\_\_\_\_

Are you at the present time using any type of chemical substances?  Yes  No  
If yes, please indicate what you are using \_\_\_\_\_

Are you presently under a physician's care for physical problems?  Yes  No  
If yes, please list medications \_\_\_\_\_

Name of physician: \_\_\_\_\_ Phone \_\_\_\_\_  
Address \_\_\_\_\_

Have you ever been arrested and/or committed a crime?  Yes  No  
If yes, when: \_\_\_\_\_ For what? \_\_\_\_\_  
Outcome? \_\_\_\_\_

What problems are you presently experiencing (please be specific)?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What do you expect from therapy? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If need be, would other family members be willing to come into therapy sessions?  
 Yes  No  
If no, please indicate reason: \_\_\_\_\_

How did you hear about us (or from whom)?  
\_\_\_\_\_

Client signature \_\_\_\_\_ Date \_\_\_\_\_