Beth Linfoot, Counseling, PLLC
31320 IH10 West Suite A
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(210) 379-3356
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Personal History Intake Packet

Client Name: ____

Date: __________________

Gender: ▫ M ▫ F Date of birth: ___________________________________

Age: ___________________

Forms completed by (if someone other than client):
____

Address: __________________________________ City: __________________________

Zip: ___________

Phone (home): _____________________ Work: _______________________ Cell:

Email Address:
____

May I contact you by: (please check all that apply)
▫ Phone call ▫ Leaving a voicemail message ▫Text Message ▫ Email ▫ U.S. Postal Mail
Emails

While every precaution is taken to ensure confidentiality on the internet, emails can be hacked and information can be seen by unwanted parties. Please initial to indicate your understanding of the associated risks with email communication and your acceptance of receiving emails.

____

Primary reason(s) for seeking services
▫ Addictive Behaviors ▫ Communication Skills ▫ Personal Growth
▫ Trauma History ▫ Coping ▫ Parenting
▫ Anger management ▫ Depression ▫ Relationship concerns
▫ Anxiety ▫ Behavioral Concerns ▫ Sexual Concerns
▫ Career/Education ▫ Fear/Phobias ▫ Sleeping Problems
▫ Grief & Loss ▫ Giftedness ▫ For other family member
▫ Separation/ Divorce ▫ Social struggles ▫ Family Conflict

▫ Other: ____

While I am happy to help, please know that a referral to a different counselor/therapist may be in order
to best meet your needs. I will happy to help you set that up if necessary.

________Please initial here to indicate your understanding of the limits of my specialties and the ethical obligation to make referrals when there is a mismatch between need and services.

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Please indicate who the services are for: ____.
Relationship to you: _____ Self _____ Other ___________________________________.
What are your goals for therapy?
____

____

____

Do you feel suicidal at this time? ▫ Yes ▫ No, if Yes, explain:
____

____
Have you experienced major changes/events during the past year? ▫ Yes ▫ No, if Yes, explain:

____

Are you presently seeing another counselor? ▫ Yes ▫ No, If Yes, Who?
____

Have you had previous counseling or psychotherapy? ▫ Yes ▫ No If Yes, please share when and for what reason.
____

____

Behaviors/Symptoms Check behaviors/symptoms that occur more often than you would like:
▫ Anger/aggression ▫ Fatigue ▫ Panic Attacks
▫ Alcohol/drug use ▫ Gambling ▫ Phobias/Fears
▫ Anti-social behavior ▫ Hallucinations ▫ Recurring thoughts
▫ Anxiety ▫ Heart Palpitations ▫ Sexual thoughts/acts
▫ Avoidance ▫ High blood pressure ▫ Sexual difficulties

□ Chest pain □ Hopelessness □ Sick often
□ Critical of self/others □ Irritability □ Sleep problems
□ Cyber/internet use □ Judgment errors □ Suicidal thought
□ Depression □ Loneliness □ Thoughts disorganized
□ Disorientation □ Memory impairment □ Withdrawing
□ Distractibility □ Mood shifts □ Worrying
□ Elevated mood □ Over/under eating

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Education/ Career
Highest Degree: __________________________ Occupation: ________________________
Degree in: _______________________________ Other: _____________________________

Military experience? □ Yes □ No If yes, please explain:
____

Family Information
*Note: Please include all people living in the home. You may use the back of the page if needed.
Marital Status
□ Single □ Living with significant other
□ Married □ Committed relationship, living apart
□ Divorced/Divorce in process □ Separated
□ Widowed □ Other: ____

Please list significant others, siblings, grandparents, half-relatives, etc.
Living? Living with you?
Relationship Name Age Yes No Yes No
Mother
Father
Spouse/Partner
Child

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Family of Origin (the family the client was born into and/or raised with)
Parents:
□ Married/Together
□ Divorced/Separated
□ Mother remarried; Number of times: _______
□ Father remarried; Number of times: ________
□ Special circumstance (e.g. raised by person other than parents)

Please describe any special circumstances:
____

Development

Are there unusual or traumatic circumstances that affected your development? ▫ Yes ▫ No
If Yes, describe:
____

Is there a history of abuse? ▫ Yes ▫ No
If Yes, which type(s)? ▫ Sexual ▫ Emotional ▫ Physical ▫ Verbal
If Yes, the abuse was as a: ▫ Victim ▫ Perpetrator
Other childhood issues: ▫ Neglect ▫ Inadequate nutrition ▫ Other: __________________________

Cultural/Ethnic

To which cultural or ethnic group do you belong?
____

Are you experiencing problems due to cultural or ethnic issues? ▫ Yes ▫ No
If Yes, please describe:
____
Other cultural/ethnic information you want to share:
____

Religious/Spiritual

How important to you are religion/spirituality? ▫ Not at all ▫ A little ▫ Moderately ▫ Very
Do you belong to a religious or spiritual group? ▫ Yes ▫ No If Yes, Which?
____
Do your religious or spiritual beliefs help you cope in life? ▫ Yes ▫ No If Yes, explain:
____

Would you like your religious or spiritual beliefs incorporated into counseling? ▫ Yes ▫ No
If yes, describe:
____

Support Network

My network of support and encouragement includes the following: (check all that apply)
▫ Myself ▫ Classmates ▫ Colleagues ▫ Neighbors
▫ Exercise class/Partner ▫ Online groups ▫ Family ▫ Friends
▫ Religious/Spiritual Group ▫ Social Networks ▫ Other: _________________________________
Recent changes to my support network include:
____

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Medical/Physical Health
Do you have (or have a history of) medical problems in the following areas:
▫ Neurological ▫ Abdominal pain or difficulties with elimination
▫ Chronic Pain ▫ Musculoskeletal
▫ Ear/Nose/Throat ▫ Skin
▫ Cardiology ▫ Respiratory
▫ Other:
____

Explanation if necessary:
____

____

Medical/Physical Health (continued)
List any recent health or physical changes:
____

____

Have you ever been hospitalized? ▫ Yes ▫ No If so, what? (Please list only those that occurred in
the last 3 years or are related to your current issue or problem.)
____

____

Substance Use Questions
Do you drink alcohol? ▫ Yes ▫ No If Yes, how much?
____

Do you use illegal drugs? ▫ Yes ▫ No If Yes, what/how much?
____

Describe when and where you typically use substances:
____

Describe how your use has affected your family and/or friends (include their perception of your use):
N/A_____

Explanation:____

____

Reasons for use: ▫ Addiction ▫ Socialization
▫ Escape ▫ Taste
▫ Self- medication ▫ Other: ______________________________

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Please read, initial, sign and date to complete the Client History Intake Packet.
Thank you for taking time to complete the Client History Intake Packet for me. While it is detailed and
lengthy, please know it is necessary to have as much information as possible to get the best picture of
your current circumstances so that an effective treatment plan can be put in place. As mentioned
earlier, if there appears to be a mismatch in your needs and our services, we w