Texas Military Department Counseling Program

CLIENT INTAKE FORM

***Prior to completing this form, please review Informed Consent for Treatment.**

For couples or family counseling, all adult parties participating in counseling will need to complete this form separately/independently. Please return prior or bring to your first session.

Demographic Information

Name: _____ DOB: _____

Home#: _____ Work#: _____ Mobile#: _____

Address: _____
Street Address City County State Zip

Email: _____

Sex (in DEERS): ☐ Female ☐ Male

Preferred Pronoun: ☐ She/Her ☐ He/Him ☐ They/Them ☐ Other _____

What is your preferred method of Contact? ☐ Email ☐ Phone

May we leave voicemails? ☐ Yes ☐ No If yes: ☐ Home ☐ Work ☐ Mobile

Rank: _____ Component: ☐ TXARNG ☐ TXANG ☐ TXSG ☐ Dependent

Brigade/Wing:_____ Years of Service:_____ Duty Status: ☐ M-DAY ☐ AGR ☐ ADOS

If on current State Active Duty orders, please list mission: _____

Ethnicity: ☐ Black/African American ☐ White/Caucasian ☐ Hispanic/Latino ☐ Other _____

Primary Language: ☐ English ☐ Spanish ☐ Other _____

Emergency Contact Name: _____

Contact #: _____ Address: _____

How were you referred to our program? ☐ BH ☐ Chaplain
☐ Commanding Officer ☐ Community Resource ☐ FSS
☐ J9 ☐ Other ☐ SAPR ☐ Self ☐ SIR

What is your reason for seeking counseling and what are you hoping to achieve? _____
_____
_____
_____

Where were you born and raised? _____

_____

Who were your primary caregiver(s), how was your relationship with them growing up, and how is your current relationship with them? _____

_____

_____

_____

How many siblings do you have, how were those relationships growing up, and how are those relationships now? _____

_____

_____

_____

Describe any other familial, socioeconomic, cultural, or educational issues that affected your childhood:

_____

_____

_____

Current living situation: ☐ lives alone ☐ living with family/friend(s)/roommate(s)
☐ homeless ☐ military housing ☐ inconsistent housing ☐ Other _____

Number of people in household and composition: _____

Marital status (in DEERS): ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Name of current spouse/partner: _____

Length of time with current spouse/partner:_____

Any relationship information (stressors, strengths, historical context) that you feel is relevant to treatment: _____

_____

_____

_____

Describe your current support system (types/names of supports, if applicable):_____

_____

_____

Do you have any children? If yes, provide name(s), age, and if whether the reside with you:

_____

_____

_____

_____

Commanding Officer Name & Contact #: _____

Deployment and activation history (location, dates, duration, and mission description): _____

_____

_____

Do you believe your issues are deployment related? ☐ Yes ☐ No

Current benefits and stressors related to service: _____

_____

_____

Current Military resources utilized: ☐ VA ☐ Peer Support Group ☐ LOD in place/pending

☐ Vet Center ☐ TX Sub Abuse Counselor ☐ MEB Pending ☐ Other: _____

History of Active Duty? ☐ Air Force ☐ Army ☐ Coast Guard ☐ Marines ☐ Navy ☐ N/A

Active Duty Duration and Date of Separation/Retirement: _____

Highest Level of Education: ☐ Associates ☐ Bachelors ☐ Masters ☐ Other

☐ High School Diploma/GED ☐ Some College ☐ Trade/Technical School

Employment: ☐ Full-Time ☐ Part-Time ☐ Looking for Employment ☐ Not Employed

Employer: _____

Current Employment Stressors? _____

Insurance: ☐ Yes ☐ No If yes, insurance company: _____

Mental Health Insurance Benefits: ☐ Yes ☐ No

Financial Status: ☐ Stable ☐ Financial Stress

Areas of Financial Need (housing, utilities, childcare, transport, credit repay, etc): _____

_____

Religious / Spiritual Practice or Belief: ☐ Yes ☐ No

Relevant religious/spiritual information (benefits, stressors, affiliation, etc): _____

_____

_____

Relevant cultural information to be considered in treatment (benefits, stressors, affiliation, practices, etc.): _____

_____

_____

Current legal involvement or pending charges: ☐ Yes ☐ No

Current or history of military-related disciplinary action(s)? If yes, provide details (issue, date, disposition): _____

_____

_____

Clinical Information and History

Current Psychiatric Treatment? ☐ Yes ☐ No

If yes, please note Psychiatric provider name:_____

What diagnosis was determined and what psychotropic medications are you currently prescribed/taking:

_____

_____

History of outpatient mental health treatment? ☐ Yes ☐ No

If yes, please provide details (timeframes, diagnosis, method of treatment, was it helpful or not helpful, etc.): _____

_____

_____

History of inpatient behavioral health hospitalization? ☐ Yes ☐ No

Family history of mental health related concerns or conditions? _____

_____

How would you describe your current physical health: _____

Current/treating medical provider: _____

Current medical conditions and/or diagnosis (include whether treated/managed well or not): _____

_____

_____

Current medications/supplements:_____

_____

History of serious accidents, illnesses, and/or medical hospitalizations: _____

_____

History of brain injury, including TBI? ☐ Yes ☐ No If yes, provide details:_____

_____

Current alcohol and/or substance use: ☐ Yes ☐ No

History of alcohol and/or substance use? ☐ Yes ☐ No

If yes, provide details: _____

_____

Family history of alcohol and/or substance misuse? ☐ Yes ☐ No

If yes, provide details: _____

_____

Any other information that you feel is relevant for your counselor to know at this time: _____

_____

_____

_____

_____