Client Intake Form

Please provide the following information below. All information will be held confidential. If there are questions that you do not wish to answer at this time, feel free to leave them blank. Please bring the completed form with you to your first session.

Name: _____
(Last) (First) (Middle initial)

Name of parent or guardian (if under 18 years old):

_____
(Last) (First) (Middle initial)

Age: _____ Birthdate: _____

Marital Status: ___ Single___ Married ___ Divorced ___ Separated ___ Widowed

___ Domestic Partnership

Please list any children and ages: _____

Home Address: _____
(Street Number)

_____
(City) (State) (Zip Code)

Home Phone: _____ ____ yes ____ no
(ok to leave message?)

Cell/Other Phone: _____ ____ yes ____ no
(ok to leave message?)

Email: _____ ____ yes ____ no
please note that email is not always considered confidential (ok to email a message?)

Referred by (if any): _____

Emergency Contact Information:

_____
(Name) (Relation) (Phone #)

Have you previously received any type of mental health services, such as counseling or psychiatric services: ___ yes ___ no

If yes: _____
(Name) (Phone)

Health and Medical

Please list current prescription psychiatric medication that you are taking, including dose and frequency:

_____

_____

_____

Please list any past prescription psychiatric medication that you have taken, including dose and frequency:

_____

_____

_____

How would you describe your current physical health (please circle one):

Poor Unsatisfactory Satisfactory Good Excellent

Please list any current medical conditions:

_____

_____

_____

Are you having any trouble with your sleeping or eating patterns (if so, please describe):

_____

_____

How often do you exercise: _____

What kinds of activities do you participate in for exercise:

_____

_____

Please check from the following list any items that you have experienced recently:

___ Loss of interest in previously enjoyed activities
___ Overwhelming sadness
___ Crying often
___ Feeling hopeless
___ Overwhelming anxiety, panic, or worry
___ Frequent physical complaints (headaches, etc)
___ Significant change in weight
___ Trouble falling asleep or staying asleep at night
___ Racing or disorganized thought patterns
___ Thoughts of suicide
___ Irritability or anger
___ Self Mutilation
___ Overindulgence in alcohol, recreational drugs, or sexual activity (circle all that apply)

Please briefly describe the significant life event or challenges that have resulted in your seeking therapy at this time:

_____

_____

_____

Family History

FAMILY MENTAL HEALTH HISTORY:

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

	Please Circle	List Family Member
Alcohol/Substance Abuse	yes	
Anxiety/Panic	yes	
Depression	yes	
Domestic Violence	yes	
Eating Disorders	yes	
Obesity	yes	
Obsessive Compulsive Behavior	yes	
Schizophrenia	yes	
Suicide Attempts	yes	

Do you have any siblings? If so, please list with ages:

_____

Who do you turn to for support?

_____

Occupational and Social

Are you currently employed? ____ yes ____ no

if yes, what is your current occupation: _____

Do you enjoy your current profession? ____ yes ____ no

if no what would you change: _____

Please list any current legal troubles at this time, if any:

_____

_____

Do you consider yourself a religious or spiritual person? ____ yes ____ no

If so, how would your describe your spiritual beliefs?

_____

_____

_____

What kind of activities or coping strategies do you use when you are stressed or overwhelmed?

_____

_____

_____

What kind of activities or pleasurable hobbies do you engage in?

_____

_____

_____

What do you view to be your strengths as a person?

_____

_____

_____

What are your goals and desires to achieve in therapy?

_____

_____

_____

Please feel free to provide any additional information that you feel is important for me to know that I have not asked about:

_____

_____

_____

_____

_____

_____

_____

_____