

## CLIENT INTAKE FORM

Please provide the following information for our records. Leave blank any question you would rather not answer. Information you provide here is held to the same standards of confidentiality as our therapy. Please print out this form and bring it to your first session or allow yourself thirty minutes prior to your appointment to complete the form in the office.

Name: \_\_\_\_\_  
(Last) (First) (Middle Initial)

Name of parent/guardian (if you are a minor):

Name: \_\_\_\_\_  
(Last) (First) (Middle Initial)

Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_ Gender:  Male  Female

Marital Status:

Never married  Partnered  Married  Separated  Divorced  Widowed

Number of Children/Ages: \_\_\_\_\_

Local Address: \_\_\_\_\_  
(Street and Number)

\_\_\_\_\_  
(City) (State) (Zip)

Home Phone: ( ) \_\_\_\_\_ May we leave a message?  Yes  No

Cell/Other Phone: ( ) \_\_\_\_\_ May we leave a message?  Yes  No

E-Mail: \_\_\_\_\_ May we e-mail you?  Yes  No

\*Please be aware that e-mail might not be confidential

Referred by: \_\_\_\_\_

Are you currently receiving psychiatric services, professional counseling or psychotherapy elsewhere?  Yes  No

Have you had previous psychotherapy?

No  Yes, at previous therapist's name: \_\_\_\_\_

Are you currently taking prescribed psychiatric medication (antidepressants or others)?

No  Yes If Yes, please list: \_\_\_\_\_

If No, have you been previously prescribed psychiatric medication?

No  Yes If Yes, please list: \_\_\_\_\_

## HEALTH & SOCIAL INFORMATION

1. How is your physical health at present?

Poor  Unsatisfactory  Satisfactory  Good  Very Good

2. Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.):

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3. Are you having any problems with your sleep habits?  No  Yes

4. If yes, check where applicable:

Sleeping too little  Sleeping too much  Poor quality sleep  Disturbing dreams  
 Other

5. Are you having difficulty with appetite or eating habits?  No  Yes

If yes, check where applicable:  Eating Less  Eating more  Binging  
 Restricting

6. Do you regularly use alcohol?  No  Yes

In a typical month, how often do you have 4 or more drinks in a 24-hour period? \_\_\_\_\_

7. How often do you engage in recreational drug use?

Daily  Weekly  Monthly  Rarely  Never

Have you had suicidal thoughts recently?  Frequently  Sometimes  Rarely  
 Never

8. Have you had them in the past?  Frequently  Sometimes  Rarely  
 Never

9. Are you currently in a romantic relationship?  No  Yes

Partner/Spouse Name: \_\_\_\_\_

If Yes, how long have you been in this relationship? \_\_\_\_\_

On a scale of 1-10, how would you rate the quality of your current relationship? \_\_\_\_\_

10. In the last year, have you experienced any significant life changes or stressors:

**Have you ever experienced:**

Extreme depressed mood:  No  Yes

Wild mood swings:  No  Yes

Rapid speech:  No  Yes

Extreme anxiety:  No  Yes

Panic Attacks:  No  Yes

Phobias:  No  Yes

Sleep Disturbances:  No  Yes

Hallucinations:  No  Yes

Unexplained losses of time:  No  Yes

Unexplained memory lapses:  No  Yes

Alcohol/Substance Abuse:  No  Yes

Frequent body Complaints:  No  Yes

Eating Disorder:  No  Yes

Body Image Problems:  No  Yes

Repetitive Thoughts (e.g. Obsessions):  No  Yes

Repetitive Behaviors (e.g. Frequent Checking, Hand Washing):  No  Yes

Homicidal Thoughts:  No  Yes

Suicide Attempt:  No  Yes

**OCCUPATIONAL INFORMATION:**

Are you currently employed?  No  Yes

If yes, who is your current employer:\_\_\_\_\_

If yes, are you happy at your current position:\_\_\_\_\_

Please list any work-related stressors:\_\_\_\_\_

**RELIGIOUS/SPIRITUAL INFORMATION:**

Do you consider yourself to be religious?  No  Yes

If yes, what is your faith?\_\_\_\_\_

If no, do you consider yourself to be spiritual?  No  Yes

FAMILY MENTAL HEALTH HISTORY:

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (check any that apply and list family member, e.g., sibling, parent, uncle, etc.):

Difficulty	Family Member
Depression: <input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Bipolar Disorder: <input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Anxiety Disorders: <input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Panic Attacks: <input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Schizophrenia: <input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Alcohol/Substance Abuse: <input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Eating Disorders: <input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Learning Disabilities: <input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Trauma History: <input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Suicide Attempts: <input type="checkbox"/> No <input type="checkbox"/> Yes	_____

OTHER INFORMATION:

What do you consider to be your strengths:\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What do you like most about yourself?\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What are effective coping strategies that you have learned?\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What are your goals for therapy?\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Emergency Contact (Name/Phone Number):**\_\_\_\_\_