CLIENT INTAKE FORM

Please answer the following questions to the best of your abilities. These questions are to help with the therapy process. This information is held to the same standards of confidentiality as our therapy.

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

Birth date: _____/_____/_____ Age:_____ Gender: Male Female Transgender (please circle)

Marital status: Never married Partnered Married Separated Divorced Widowed

Number of children: _____ Ages:_____

Home address: _____
Alternate (school) address: _____

Home phone:_____ May we leave a message? Yes No
Cell/other: _____ May we leave a message? Yes No
Email:_____ May we email you?* Yes No
*NOTE: Emails may not be confidential

Referred by:_____

Are you currently receiving psychological services, professional counseling, psychiatric services, or any other mental health services? Yes _____ No _____ for what reason?
_____
_____

Have you had any mental health services in the past? Yes ____ No _____ for what reason?
_____
_____

Are you currently taking any psychiatric prescription medication? Yes _____ No _____
If yes, please list:
_____

Have you been prescribed psychiatric prescription medication in the past? Yes _____ No _____
If yes, please list:
_____

Have you ever been hospitalized for any mental health condition, including substance abuse treatment? If yes, please describe type and dates of treatment.

_____

_____

General Health and Mental Health Information

How is your physical health at the present time? Poor Unsatisfactory Satisfactory Good Very good

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

_____

_____

Are you on any medication for physical/medical issues? Yes _____ No _____
If yes, please list:

_____

Are you having any problems with your sleep habits? Yes _____ No _____
How many hours do you sleep each night? _____

Circle those that apply to sleep problems:
Sleep too much Sleep too little Poor quality Disturbing dreams other: _____

How many times per week do you exercise? _____ days _____ minutes/hours
If yes, what type of exercise?
Are there any recent changes or difficulties with your eating habits? Yes _____ No _____
Is there a history of any disordered eating? Yes _____ No _____
If yes, circle one:

Eating less _____ eating more _____Bingeing _____ Restricting _____

Any history of self-harm? _____ Last time it occurred _____

Have you experienced a weight change in the last two months? Yes ____ No _____
If so, what changed? _____

How often do you consume alcohol? # drinks per day _____ # drinks per week _____

In one month, how many times do you have four or more drinks in a 24-hour period? _____

How often do you engage in recreational drug use? Daily Weekly Monthly Rarely Never
What drugs have you used in the past? _____
Which drugs, if any, are you currently using?
_____

Have you felt depressed recently? Yes _____ No _____ If yes, for how long?
_____
What symptoms are you experiencing from depression?
_____

Have you had any suicidal thoughts in the past 1-3 months? Yes _____ No _____
If yes, how often? _____ Last time you had suicidal thoughts, with or without plan?_____
Have you ever had suicidal thoughts in your past? Yes _____ No _____ If yes, how long ago?
_____
How often did you have these thoughts? _____ (daily, weekly)
Were you ever hospitalized due to suicidal thoughts or attempts? _____

Are you currently in a romantic relationship? Yes _____ No _____ If yes, how long? _____
On a scale from 1-10 (10 being great), how would you rate the quality of your relationship? _____

In the last year, have you had any major life changes (e.g. new job, moving, illness, relationship change, etc.)?
_____
_____

Quick Check
Circle the issues below that apply to you.

Extreme depressed mood	Mood swings	Rapid speech	Extreme anxiety
Panic attacks	Phobias	Sleep disturbance	Hallucinations
Memory lapse	Alcohol/substance abuse	Body complaints	Eating disorder
Repetitive thoughts	Anxiety	Time loss	Repetitive behaviors
Homicidal thoughts	Suicide attempts	Trouble planning	Difficulty with relationships

Occupational/School Information

Are you currently employed? Yes _____ No _____

If yes, who is your employer? _____ Position/Title: _____

Are you content in your current position? Yes _____ No _____

Does your work make you stressed? Yes _____ No _____

Are you in school? Yes _____ No _____ If yes, what are you studying? _____

Religious/Spiritual Information

Do you practice a religion? Yes No

If yes, what is your faith? _____

If no, do you consider yourself to be spiritual? _____ Agnostic? _____ Athiest? _____

Family Mental Health History

The following is to provide information about your family history. Please mark each as yes or no. If yes, please indicate the family member affected.

Depression	Yes	No	_____
Anxiety Disorders	Yes	No	_____
Bipolar Disorder	Yes	No	_____
Panic Attacks	Yes	No	_____
Alcohol/Substance Abuse	Yes	No	_____
Eating Disorder	Yes	No	_____
Learning Disability	Yes	No	_____
Trauma History	Yes	No	_____
Domestic Violence	Yes	No	_____
Obesity	Yes	No	_____
Obsessive Compulsive Behavior	Yes	No	_____
Schizophrenia	Yes	No	_____

Other Information

List your strengths

_____

_____

_____

List areas you think you need to develop

_____

_____

What are some ways you cope with life obstacles and stressors _____

_____

_____

What are your goals for therapy/what would you like to accomplish?

_____

_____

_____

_____

Client Printed Name

_____ _____

Client Signature Date