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Client Intake Form

Please note: information you provide on this form is protected as confidential information.

Name:____ Date:__________________
(Last) (First) (Middle)

Name of parent/guardian (if under age 18):
____

Date of Birth: _______________________ Gender:___________________________________

Address:____
(street and number) (unit number)

_____________________________________ _________________ ___________________
(city) (state) (zip code)

Home number: ____
May we leave a message? Yes No

Cell number: ____
May we leave a message? Yes No

Email: ____
Please note: Email correspondence is not considered to be a confidential medium of communication.

Would you like to receive our monthly newsletter? Yes No

Emergency Contact Name & Phone:____
Relationship to You: ____

Relationship status: ☐Never Married ☐Domestic Partnership ☐Married
☐Separated ☐Divorced ☐Widowed

Please list children & ages: (if applicable)

____

Are you pregnant? Yes No

Employed: ☐Full-Time ☐Part-Time ☐Stay at home parent ☐Student ☐Unemployed

Referral Source:____

Are you currently receiving any type of mental health services? (psychotherapy, psychiatric services, etc.)____

If yes, name of therapist/practitioner:_____________________________________
Have you previously received any type of mental health services? (psychotherapy, psychiatric services, etc.) ____

If yes, name of previous therapist/practioner:_______________________________

How would you describe your experience?__________________________________
____
____

What did you find most helpful about participating in therapy?__________________
____
____

What did you find least helpful about participating in therapy?__________________
____
____

Have you ever been diagnosed with a mental illness?_________________________

If yes, please list the illness(es) and date(s) first diagnosed:___________________
____

Have you ever been hospitalized for mental health concerns? __________________

If yes, please list dates:____

Please list any specific health problems you are currently experiencing:___________
____
____

Are you currently taking any prescription medicine? _________________________

If yes, please list the names of the medication(s):____________________________
____

Are you currently taking any vitamins/supplements?_______________________________

If yes, please list:____

Have you previously taken any psychiatric medications?___________________________

If yes, please list the names of the medication(s):_______________________________
____

Do you engage in recreational drug use?_________ If yes, how often? _________________

Are you currently receiving any alternative healing treatments?(acupuncture, reiki, etc.)
____
____
____

Do you exercise?______________ If yes, how many times per week? _________________

Have you ever experienced any of the following:

Anxiety, panic attacks or phobias	☐Yes	☐No	☐Currently	☐In the past
Sleep problems	☐Yes	☐No	☐Currently	☐In the past
Difficulties with eating patterns/appetite	☐Yes	☐No	☐Currently	☐In the past
Excessive shame/guilt	☐Yes	☐No	☐Currently	☐In the past
Sadness, grief or depression	☐Yes	☐No	☐Currently	☐In the past
Chronic pain	☐Yes	☐No	☐Currently	☐In the past
Flashbacks	☐Yes	☐No	☐Currently	☐In the past
Weight loss/gains	☐Yes	☐No	☐Currently	☐In the past
Confusing/racing/intrusive thoughts	☐Yes	☐No	☐Currently	☐In the past
Frequent crying	☐Yes	☐No	☐Currently	☐In the past
Isolation/Loneliness	☐Yes	☐No	☐Currently	☐In the past
Restlessness	☐Yes	☐No	☐Currently	☐In the past
Difficulty concentrating	☐Yes	☐No	☐Currently	☐In the past
Moodiness/irritability	☐Yes	☐No	☐Currently	☐In the past
Memory problems	☐Yes	☐No	☐Currently	☐In the past
Suicidal Thoughts	☐Yes	☐No	☐Currently	☐In the past
Suicide Attempts	☐Yes	☐No	When? ________________	
Grief/loss	☐Yes	☐No	☐Currently	☐In the past
Sexual problems	☐Yes	☐No	☐Currently	☐In the past
Financial problems	☐Yes	☐No	☐Currently	☐In the past
Work problems	☐Yes	☐No	☐Currently	☐In the past
Family problems	☐Yes	☐No	☐Currently	☐In the past
Relationship problems	☐Yes	☐No	☐Currently	☐In the past

Self-Esteem issues	☐Yes	☐No	☐Currently	☐In the past
Excessive alcohol use	☐Yes	☐No	☐Currently	☐In the past
Physical Abuse	☐Yes	☐No	☐Currently	☐In the past
Emotional Abuse	☐Yes	☐No	☐Currently	☐In the past
Sexual Abuse/Assault	☐Yes	☐No	☐Currently	☐In the past
Domestic Violence	☐Yes	☐No	☐Currently	☐In the past

What significant life changes or stressful events have you experienced recently?___________
____
____
____

Are you currently in a romantic relationship?_________ If yes, how long?________________

How would you rate it?____

Do you consider yourself to be religious or spiritual?_________________________________

If yes, please describe:____
____
____

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

Alcohol/Substance abuse	☐Yes	☐No	Family Member__________________
Anxiety	☐Yes	☐No	Family Member__________________
Bipolar Disorder	☐Yes	☐No	Family Member__________________
Depression	☐Yes	☐No	Family Member__________________
Domestic Violence	☐Yes	☐No	Family Member__________________
Eating disorder	☐Yes	☐No	Family Member__________________
Obsessive compulsive disorder	☐Yes	☐No	Family Member__________________
Schizophrenia	☐Yes	☐No	Family Member__________________
Suicide Attempts	☐Yes	☐No	Family Member__________________

What is your primary reason for deciding to begin therapy?____________________________
____
____
____

What would you like to accomplish in therapy?_______________________________________
____
____

Please list any additional information you feel would be helpful for me to know:___________
____