

Client Intake

- ❖ Please provide the following information and answer the questions below
- ❖ Information you provide here is protected as confidential information
- ❖ Please fill out this form and bring it to your first session

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

Name of parent/guardian (if under 18 years):

(Last) (First) (Middle Initial)

Birth Date: _____ / _____ / _____ Age: _____ Gender: Male Female

Marital Status: Never Married Separated Domestic Partnership
 Married Divorced Widowed

Please list any children / age: _____

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

Email: _____ May we email you? Yes No

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

Referred by (if any): _____

Have you previously received any mental health services? (psychotherapy, psychiatric services, etc.)

No
 Yes, previous therapist / practitioner: _____

Are you currently taking any prescription medication?

No
 Yes, please list: _____

Have you ever been subscribed psychiatric medication?

No

Yes, please list and provide dates: _____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION:

1. How would you rate your current physical health?

Poor

Unsatisfactory

Satisfactory

Good

Very Good

Please list any current health problems you are currently experiencing:

2. How would you rate your current sleeping habits?

Poor

Unsatisfactory

Satisfactory

Good

Very Good

Please list any specific sleeping problems you are currently experiencing:

3. How many times a week do you generally exercise? _____

What types of exercise do you participate in?

4. Please list any difficulties you experience with your appetite or eating patterns:

5. Are you currently experiencing overwhelming sadness, grief, or depression?

No

Yes

If yes, for approximately how long? _____

6. Are you currently experiencing anxiety, panic attacks, or have any phobias?

No

Yes

If yes, when did you begin experiencing this? _____

7. Are you currently experiencing any chronic pain?

- No
 Yes

If yes, please describe _____

8. Do you drink alcohol more than once a week? Yes No

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

- Daily Weekly Monthly Infrequently Never

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

If yes, for how long? _____

On a scale of 1-10, how would you rate your relationship? _____

11. What significant life changes or stressful events have you experienced recently?

FAMILY MENTAL HEALTH INFORMATION:

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.).

			List Family Member
Alcohol / Substance Abuse	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Anxiety	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Depression	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Domestic Violence	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Eating Disorders	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Obesity	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Obsessive Compulsive Behavior	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Schizophrenia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Suicide Attempts	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____

ADDITIONAL INFORMATION:

1. Are you currently employed? Yes No

If yes, what is your current employment situation?

2. Do you enjoy your work? Is there anything stressful about your current work?

3. Do you consider yourself to be spiritual or religious? Yes No

If yes, please describe your faith or belief.

4. What do you consider to be some of your strengths?

5. What do you consider to be some of your weaknesses?

6. What would you like to accomplish out of your time in therapy?

7. Is there any additional information you would like to provide?
