Intake Form

Client Information

- Full Name:
- Date of Birth:
- Gender:
- Pronouns:
- Phone Number:
- Email Address:
- Address:

City: State: Zip:

Emergency Contact

- Name:
- Relationship:
- Phone Number:

Presenting Issues (Check all that apply)

[ ] Anxiety [ ] Depression [ ] Relationship Issues [ ] Trauma/PTSD

[ ] Grief/Loss [ ] Self-Esteem [ ] Stress Management [ ] Substance Use

[ ] Life Transitions [ ] Other: _____

Brief description of your main concern:

_____

_____

Medical & Mental Health History

- Are you currently seeing a doctor or psychiatrist? [ ] Yes [ ] No

If yes, who and for what reason?

_____

- Current medications:

_____

- Any past mental health diagnoses or hospitalizations?

[ ] Yes [ ] No — If yes, please explain:

_____

- History of substance use:

[ ] Yes [ ] No — If yes, please describe:

_____

Family & Social History

- Relationship status: [ ] Single [ ] In a relationship [ ] Married [ ] Divorced [ ] Widowed

- Children? [ ] Yes [ ] No — If yes, ages: _____

- Support system (friends/family you can rely on):

_____

- Any history of mental health issues in your family?

[ ] Yes [ ] No — If yes, please explain:

_____

Safety

- Have you ever had thoughts of harming yourself or others?

[ ] Yes [ ] No — If yes, when and what actions did you take?

_____

Goals for Therapy

What would you like to achieve through therapy?

_____

_____

Consent & Confidentiality

By signing below, I acknowledge that the information provided is accurate to the best of my knowledge. I understand the nature and limits of confidentiality in therapy.

Signature: _____ Date: _____

Patient Health Questionnaire and General Anxiety Disorder (PHQ-9 and GAD-7)

Date_____ Patient Name:_____ Date of Birth: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?
Please circle your answers.

PHQ-9	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things.	0	1	2	3
2. Feeling down, depressed, or hopeless.	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much.	0	1	2	3
4. Feeling tired or having little energy.	0	1	2	3
5. Poor appetite or overeating.	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down.	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television.	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way.	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all **Somewhat difficult** **Very Difficult** **Extremely Difficult**

Over the last 2 weeks, how often have you been bothered by any of the following problems?
Please circle your answers.

GAD-7	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge.	0	1	2	3
2. Not being able to stop or control worrying.	0	1	2	3
3. Worrying too much about different things.	0	1	2	3
4. Trouble relaxing.	0	1	2	3
5. Being so restless that it's hard to sit still.	0	1	2	3
6. Becoming easily annoyed or irritable.	0	1	2	3
7. Feeling afraid as if something awful might happen.	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all **Somewhat difficult** **Very Difficult** **Extremely Difficult**

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