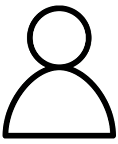

Identities Counseling

Client Intake Form

Intake Date: ____/______/_______

Legal Last Name: ________________________ Legal First Name: __________________________

Preferred Name: ________________________

Legal Gender: ________ Gender Identity: ________ Preferred Gender Pronouns: ____________

Current Address: ____

City: _________________ State: _________ Zip Code: ____________ County: ______________

Contact Phone Number: _________________________ Cell __ Landline __ Personal __ Work __

Okay to Leave Voicemail Message: Y_____ N ____ Okay to Send Text Messages Y ____ N _____

Emergency Contact: ____
(Name, Address and Phone Number)

D.O.B ______/______/_______ Age: ________ Social Security Number ______-______-______.

Insurance Provider ___________________________ Policy/ID # ___________________________

Group # _____________________ Co-Pay Amount $__________ Deductible $ ______________

What brings you here today?

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____

Mental Health History:

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____

Previous Therapist(s): ____
(Name Address and Phone Number)

Psychiatrist: ____
(Name Address and Phone Number)

Primary Care Physician: ____
(Name Address and Phone Number)

Current Symptoms Checklist (please check all appropriate columns)

	Mild	Moderate	Severe		Mild	Moderate	Severe
Aggression				Judgment errors			
Agitation				Loneliness			
Anger				Loss of interest in activities			
Anxiety				Memory impairment			
Appetite change				Mood swings			
Change in libido				Obsessions			
Compulsions				Oppositional behavior			
Crying/tearful				Panic attacks			
Cyber addiction				Paranoia			
Delusions				Phobias/fears			
Depression				Physical trauma perpetrator			
Disorientation				Physical trauma victim			
Difficulty getting out of bed				Poor concentration			
Difficulty making decisions				Poor grooming			
Distractibility				Racing thoughts			
Eating disorder				Recurring thoughts			
Elevated mood				Self-mutilation			
Emotional trauma perpetrator				Sexual addiction			
Emotional trauma victim				Sexual difficulties			
Excessive energy				Sexual trauma perpetrator			
Fatigue				Sexual trauma victim			
Grief				Sleep problems			
Guilt				Speech problems			
Gambling				Social isolation			
Hallucinations				Substance abuse			
Hearing voices				Suicidal thoughts			
Heart palpitations				Worried			
Hopelessness				Worthlessness			
Hyperactivity				Other:			
Impulsivity				Other:			
Irritability				Other:			

MEDICAL HISTORY

Current Medications

Medication Name	Total Daily Dosage	Estimated Start Date

EMOTIONAL/PSYCHIATRIC HISTORY

Prior Outpatient Treatment? ☐ Yes ☐ No If yes, please describe:

Reason	Dates Treated	By Whom

Prior Inpatient Treatment (for psychiatric, emotional, or substance abuse disorder)? ☐ Yes ☐ No If yes, please describe:

Reason	Date Hospitalized	Where

Current Substance Use:

____

____

Anything Else You Would Like Us to Know?

____

____

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