CLIENT INTAKE FORM
(Adult Clients)

Please provide the following information for our records. Leave blank any question you would rather not answer. Information you provide here is held to the same standards of confidentiality as our therapy. Please print out this form and bring it to your first session or allow yourself thirty minutes prior to your appointment to complete the form in the office.

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

Preferred Name: _____

Birth Date: _____ /_____ /_____ Sex/Gender: ____/_____

Name & birthdate of Primary Insured: _____/_____
(Last) (First) (Mo/Da/Yr)

Marital Status: □ Never Married □ Partnered □ Married □ Separated
□ Divorced □ Widowed

Number of Children/Dependents: _____

Local Address: _____
(House number & Street) (Apt./Unit #)

_____
(City) (State) (Zip)

Preferred Phone: _____ OK to leave a message? □ Yes □ No

E-mail: _____ OK to email you? □ Yes □ No

Emergency contact: _____
(Name) (Relationship) (Phone number)

Are you currently receiving psychiatric services, professional counseling, or psychotherapy elsewhere? □ Yes □ No
If Yes, Where? _____
May we contact them? □ Yes □ No (If yes, please sign a Release of Information form)

Have you had previous psychotherapy? □No □Yes
If Yes, Where? _____
When? _____ to _____ (approximate dates)
Reason for leaving: _____

Are you currently taking prescribed psychiatric medication (antidepressants or others)?
□Yes □No If Yes, please list: _____
_____

If no, have you been previously prescribed psychiatric medication?
□Yes □No If Yes, please list type, & reason for terminating use?: _____
_____

HEALTH AND SOCIAL INFORMATION

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

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

Are you having any problems with your sleep habits? □ No □ Yes

- If yes, check where applicable:

□ Sleeping too little □ Sleeping too much □ Poor quality sleep □ Disturbing dreams
□ Other _____

How many times per week do you exercise? _____

- Type of exercise/physical activity: _____
- Approximately how long each time? _____

Are you having any difficulty with appetite or eating habits? □ No □ Yes

- If yes, check where applicable: □ Eating less □ Eating more □ Binge eating

□ Restricting □ Dieting

Have you experienced significant weight change recently? □ No □ Yes

Do you regularly consume alcohol? □ No □ Yes
In a typical month, how often do you have 4 or more drinks in a 24-hour period? _____

How often do you engage in recreational drug use?
□ Daily □ Weekly □ Monthly □ Rarely □ Never

Do you use medically prescribed marijuana? □ No □ Yes

Have you had suicidal thoughts recently? □ No □ Yes

- If yes, please describe: _____
_____
- Have you had them in the past? □ No □ Yes: When? _____
- Have you ever attempted suicide? □ No □ Yes: When? _____
- Do you ever cause yourself harm? □ No □ Yes

Are you currently in a romantic relationship? □ No □ Yes

- If yes, how long have you been in this relationship? _____
- On a scale of 1-10, how would you rate the quality of your current relationship? _____

(1= very poor; 10= perfect)

In the last year, have you experienced any significant life changes or stressors? □ No □ Yes
If yes, please describe: _____
_____

Have you ever experienced:

(Please use this space to elaborate if needed)

- Extreme depressed mood: □ No □ Yes
- Wild Mood Swings: □ No □ Yes
- Rapid Speech: □ No □ Yes
- Extreme Anxiety: □ No □ Yes
- Panic Attacks: □ No □ Yes
- Phobias: □ No □ Yes
- Sleep Disturbances: □ No □ Yes
- Delusions/Hallucinations: □ No □ Yes
- Unexplained losses of time: □ No □ Yes
- Unexplained memory lapses: □ No □ Yes
- Alcohol/Substance Abuse: □ No □ Yes
- Frequent Body Complaints: □ No □ Yes
- Eating Disorder: □ No □ Yes
- Body Image Problems: □ No □ Yes
- Obsessive Thoughts: □ No □ Yes
- Repetitive Behaviors: □ No □ Yes

- Homicidal Thoughts: □ No □ Yes

OCCUPATIONAL INFORMATION:

Are you currently employed? □ No □ Full-time □ Part-time □ Student
If Yes:

- who is your current employer/school? _____
- what is your job title/position? _____
- are you happy there? □ No □ Yes

Please list any *significant* work-related stressors, if any: _____
_____

RELIGIOUS/SPIRITUAL INFORMATION:

Do you consider yourself to be religious? □ No □ Yes

- If yes, what is your faith? _____

Do you consider yourself to be spiritual? □ No □ Yes

- If yes, please describe briefly: _____

FAMILY MENTAL HEALTH HISTORY:

Has anyone in your family experienced difficulties with the following? (check any that apply and list family member, e.g., Sibling, Parent, Uncle, etc.):

Difficulty:		Family Member:
Depression:	□ No □ Yes	_____
Bipolar Disorder:	□ No □ Yes	_____
Anxiety Disorders:	□ No □ Yes	_____
Addictions:	□ No □ Yes	_____
Eating Disorders:	□ No □ Yes	_____
Trauma History:	□ No □ Yes	_____

Suicide Attempts: □ No □ Yes _____
OTHER INFORMATION:

What do you consider to be your strengths? What you you like most about yourself?
_____
_____
_____
_____
_____

How do you usually cope with difficulties? _____
_____
_____

Please list 2-3 short term goals (3-6 months): _____
_____
_____
_____

Please list 2-3 long-term goals (1-5 years): _____
_____
_____
_____

Therapist Notes: _____
_____
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Date Completed: _____