

Client Intake

CLIENT INTAKE FORM - ADULT

Name _____

Date _____

Take a moment to read through and answer the questions below. Your answers will help guide your initial interview and help your therapist in better understanding your current concerns, and how they can best assist you in meeting your goals from therapy at this time.

If any questions do not apply to you at this time, simply indicate this by answering N/A.

Please describe briefly what brings you to therapy at this time:

Do you have any particular goals you wish to achieve with therapy?

Please list all medications & supplements you are currently taking & why (to the best of your knowledge)

Who is your current primary care physician? (please include name, phone number & practice/clinic)

Do you drink alcohol? If yes, please specify type (beer, wine, liquor etc), amount & frequency.

Do you use recreational drugs? If yes, please specify type, amount & frequency.

What is your level of education? Did you complete high school, study at university, etc

What is your current occupation? How long have you been in this role?

What are the stressors in your life right now?

How do you currently try to reduce or manage your stress?

How is your sleep? Have you for example experienced increased or decreased sleep recently?

What do you do that makes you feel good/energised?

What does your support system look like? (family, friends, etc)

Have you seen a mental health professional before? If yes, how was your experience?

Is there anything else you think I should know about you or your recent experiences?

Have you experienced any of the following in the last 6 months?

- | | |
|--|--|
| <input type="checkbox"/> Increased appetite | <input type="checkbox"/> Decreased appetite |
| <input type="checkbox"/> Trouble concentrating | <input type="checkbox"/> Low motivation |
| <input type="checkbox"/> Difficulty sleeping | <input type="checkbox"/> Excessive sleep |
| <input type="checkbox"/> Fatigue/low energy | <input type="checkbox"/> Tearful or crying spells |
| <input type="checkbox"/> Low self-esteem | <input type="checkbox"/> Excessive worry or rumination |
| <input type="checkbox"/> Depressed mood | <input type="checkbox"/> Feelings of fear |
| <input type="checkbox"/> Hopelessness | <input type="checkbox"/> Feelings of panic |

Have you experienced/been diagnosed with any of the following?

- | | |
|--|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Upset stomach | <input type="checkbox"/> Hormone-related issues |
| <input type="checkbox"/> Head injury | <input type="checkbox"/> Chest pain |
| <input type="checkbox"/> Irritable bowel | <input type="checkbox"/> Chronic pain |
| <input type="checkbox"/> Loss of consciousness | <input type="checkbox"/> Heart/artery issues |
| <input type="checkbox"/> Bone/joint problems | <input type="checkbox"/> Seizures or epilepsy |
| <input type="checkbox"/> Kidney-related issues | <input type="checkbox"/> Chronic fatigue |
| <input type="checkbox"/> Dizziness/faintness | <input type="checkbox"/> Numbness/tingling |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Weakened immune system |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Cancer |