LIFESIMPLY
THERAPY

INTAKE FORM

Date given to therapist :

Name **Birthdate:**
Phone # **Email:**
Full Street Address:

MARITAL STATUS: **single** **married** **divorced** **widow**

IF MINOR OR AN ADULT WITH A LEGAL GUARDIAN:
PARENT/ OR GUARDIAN(S)NAME:

EMERGENCY CONTACT PERSON AND PHONE NUMBER:

YOUR OCCUPATION: **REFERRAL SOURCE:**

PRIMARY CONCERN OR PURPOSE FOR THERAPY:

1.
2.
3.

GENERAL HEALTH :
POOR **FAIR** **GOOD** **EXCELLENT**

AMOUNT OF ALCOHOL DAILY: CIGARETTES:
DO YOU EXERCISE DAILY: WEEKLY:
HOW MUCH WATER DO YOU DRINK DAILY:
TIME SPENT OUTDOORS DAILY: VITAMIN D:
HOW MANY HOURS OF SLEEP DAILY:
HOW MANY CUPS OF COFFEE/TEA DAILY/ENERGY DRINKS:
DO YOU HAVE FAMILY MEMBERS WITH ALCOHOL/DRUG PROBLEMS?

DO YOU THINK YOU HAVE A PROBLEM WITH ALCOHOL/DRUG USE?
DO OTHERS THINK YOU HAVE?

DO YOU OR YOUR CHILD (if client) CURRENTLY EXPERIENCE CONCERNS WITH :
HEADACHES_____STOMACHACHES_____DIARRHEA_____
CONSTIPATION____SHORTNESS OF BREATH_____ FREQUENT URINATION_____
BED WETTING_____ NIGHTMARES/SLEEP TERRORS_____ MUSCLE TENSION_____
BODY ACHES OR PAIN_____ HORMONAL/MENSTRUAL PROBLEMS_____
RESTLESS OR HYPERACTIVE BEHAVIOR_____ AVOIDANT BEHAVIORS_____
SLEEP IMPAIRMENT (TOO MUCH OR TOO LITTLE)_____ IMPAIRED
CONCENTRATION_____ANXIETY_____ FEELINGS OF PANIC_____ SEXUAL
PROBLEMS_____ DEPRESSION_____ FATIGUE OR LOSS OF ENERGY_____
RECENT NOTABLE WEIGHT LOSS OR GAIN_____ FEELINGS OF
WORTHLESSNESS_____ AGRESSIVE BEHAVIOR_____ SUICIDAL THOUGHTS OR
FEELINGS OF CAUSING HARM TO ONESELF OR OTHERS_____
THYROID ISSUES_____ RECENT SIGNIFICANT LOSS/GRIEF_____
RECENT LIFE ADJUSTMENT (S)_____
EXPLAIN:

ARE YOU UNDER THE CARE OF A DOCTOR AT THE MOMENT AND FOR WHAT PURPOSE?
DR.'S NAME & CONTACT INFO:
CURRENT DIAGNOSIS IF APPLIES:
CURRENT MEDICATIONS AND FOR WHAT CONDITION:

DO YOU GIVE US PERMISSION TO COORDINATE CARE WITH YOUR PHYSICIAN IF APPLICABLE?

HAVE YOU EVER:
- INTENTFULLY CAUSED HARM TO YOURSELF?
- HAD SUICIDEAL IDEATION, SUICIDAL PLAN OR MADE A SUICIDAL ATTEMPT?
- FEEL AT RISK OF CAUSING HARM OR DEATH TO YOURSELF AT THIS TIME?
- HAVE CAUSED HARM OR CONSIDER YOURSELF A RISK TO OTHERS?

HAVE YOU BEEN HOSPITALIZED FOR MENTAL HEALTH RELATED CONCERNS?
IF SO, WHERE AND WHEN:

PRIOR THERAPY EXPERIENCE? WHERE/WHEN?
LENGTH OF TREATMENT? OUTCOME?

PERSONAL HISTORY:

HAVE YOU EVER BEEN A VICTIM OF:
- SEXUAL VIOLENCE ABUSE
- EMOTIONAL ABUSE/NEGLECT
- PHYSICAL VIOLENCE OR ABUSE/NEGLECT

EXPLAIN:

ARE YOU IN AN ABUSIVE RELATIONSHIP NOW?

ARE YOUR CHILDREN ABUSED OR AT RISK OF ABUSE?
DO YOU CONSIDER YOURSELF ABUSIVE TO OTHERS?

HAVE YOU EXPERIENCED SIGNIFICANT TRAUMA OR HAD EXPERIENCES THAT HAVE KNOWINGLY IMPACTED YOUR GROWTH AND DEVELOPMENT?
EXPLAIN:

MENTAL HEALTH HISTORY WITH SELF:

KNOWN MENTAL HEALTH HISTORY OF FAMILY MEMBERS**:**

ARE YOU PREGNANT?
IF SO, WHAT FEELINGS HAS THIS PREGNANCY EVOKED?
HAVE YOU EXPERIENCED DEPRESSION WITH THIS OR PAST PREGNANCIES OR PREVIOUS PREGNANCIES?
ARE YOU CONCERNED ABOUT YOUR OWN ABILITY TO COPE WITH CURRENT STRESSORS?

GENERAL CURRENT LEVEL OF FUNCTIONING (SCALE 1-10):
DO YOU HAVE THE FOLLOWING:

LEGAL_____	FINANCIAL_____	FAMILY
PROBLEMS_____	RELATIONSHIP_____	OCCUPATIONAL_____
SCHOOL/ACADEMIC_____	OTHER_____	

PLEASE BRIEFLY EXPLAIN:

FROM WHERE DO YOU BEST GAIN EMOTIONAL SUPPORT?
IS THIS SUPPORT ADEQUATE?

ARE YOU OVERLY CHALLENGED IN YOUR PARENTING ROLE (IF APPLICABLE)?
WHAT IS NEEDED DIFFERENT?

HOW HEALTHY DO YOU CONSIDER YOUR PRIMARY RELATIONSHIP(S)? (1-10)
HOW MUCH TIME TO YOU /PARTNER/ SPOUSE SPEND TOGETHER WITHOUT CHILDREN WEEKLY (IF APPLICABLE)?
DO YOU FEEL SUPPORTED BY YOUR SPOUSE?
DOES YOUR SPOUSE LIKELY FEEL SUPPORTED BY YOU?

GOALS OF TREATMENT
WHAT ARE YOUR PRIMARY GOALS FROM THERAPY?

HOW MOTIVATED ARE YOU TO WORK HARD FOR CHANGE? (1-10)

PLEASE DRAW A FREE FORM
FAMILY TREE:
(PLEASE INCLUDE SELF, SPOUSE, CHILDREN, STEP CHILDREN, ALSO SIBLINGS AND PARENTS) – this does not need to be elaborate art!

THANK YOU,

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