

# Elizabeth Bussian, LCSW Psychotherapy

## CLIENT INTAKE FORM

Please provide the following information for my records. All of the information will be held confidential in your client file. If you have any questions that you do not wish to answer at this time, feel free to leave them blank.

Name: \_\_\_\_\_ Preferred Nick Name: \_\_\_\_\_

Date of birth: \_\_/\_\_/\_\_\_\_

Self identified gender: Female \_\_ Male \_\_ Non-Binary \_\_ Transgender \_\_  
Prefer not to disclose \_\_

Status: *Never Married* \_\_ *Married* \_\_ *Divorced* \_\_ *Separated* \_\_ *Widowed* \_\_ *Domestic Partnership* \_\_

Please list any children / ages:

\_\_\_\_\_

Home address: \_\_\_\_\_

Best phone #: \_\_\_\_\_ ok to leave message? Y\_\_ N\_\_

Email: \_\_\_\_\_

*\*please note email is not always guaranteed to be confidential*

How did you find out about this practice? \_\_\_\_\_

Emergency contact information (name/relation/phone/information limitation):

\_\_\_\_\_

\_\_\_\_\_

Have you been in therapy before? (length of time/what was your experience?)

\_\_\_\_\_

\_\_\_\_\_

Please list current prescription medications (dose/frequency):

\_\_\_\_\_

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How would you describe your current physical health?

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Please note any medical conditions:

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Please check from the following list anything you have experienced recently:

- Loss of interest in previously enjoyable activities
- Overwhelming sadness
- Crying often
- Feeling hopeless
- Overwhelming anxiety, panic or worry
- Frequent physical complaints
- Significant weight change
- Trouble falling/staying asleep
- Racing or disorganized thought patterns
- Thoughts of suicide
- Irritability or anger
- Mood shifts
- Self harm
- Over indulgence in alcohol, recreational drugs, sexual activity or impulsive spending

Please describe briefly the significant life event or challenges that resulted in you seeking therapy at this time:

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**Family History:**

Please list any medical (physical and mental health) conditions that exist/existed within your family:

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Is there a history of drug/alcohol abuse/addiction in your family?

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Is there a history of suicide in your family?

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Do you have any siblings? If so, please list ages:

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**Occupation/Social:**

Are you currently employed/self employed? \_\_\_ yes \_\_\_ no

What is your occupation? \_\_\_\_\_

Do you enjoy your occupation? \_\_\_ yes \_\_\_ no

If no, what would you change? \_\_\_\_\_

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Please list (if applicable) any current legal challenges: \_\_\_\_\_

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Do you consider yourself a spiritual / religious person? \_\_\_ yes \_\_\_ no

How would you describe your relationship to your faith/beliefs? \_\_\_\_\_

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What are your coping strategies when you are stressed? \_\_\_\_\_

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What do you engage in for self care? \_\_\_\_\_

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What do you consider your strengths to be? \_\_\_\_\_

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What are your goals for the therapy process? \_\_\_\_\_

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Please provide any information that you think would be important for me to know that was not asked:

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