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CLIENT INTAKE FORM

Todays Date:_____

Referred by: _____

GENERAL INFORMATION

Name: _____Preferred Name:_____

Street address: _____

City, State, Zip:_____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Email Address (for zoom appointments and appointment coordination):

My relationship status is _____
Alternatively, you may select all that apply:

- Single, never married
- Divorced
- Married
- Civil Union
- Domestic partnership/living with a partner
- Partnered, not living together
- Polyamorous/non-monogamous
- Widowed/grieving the loss of a partner
- Declined to answer_____

Children? Yes No If yes, custody status: _____

Name of Child/Emerging Adult: _____Age: _____

Name of Child/Emerging Adult: _____Age: _____

Name of Child/Emerging Adult: _____Age: _____

Name of Child/Emerging Adult: _____Age: _____

TREATMENT OF A MINOR OR CHILD

Parent or Legal Guardian Name:_____
I give consent for treatment _____ (Initial)
Child's Name _____ Age/Grade:_____/_____

Pronouns: Circle below pronouns for Child or Emerging Adult:

She/Her/Hers	He/Him/His	Ze/Hir/Hirs
They/Them/Theirs	No Pronoun	No Preference
Not Listed:		

Child or Emerging Adult Gender Identity:

- Agender
- Bisexual
- Asexual
- Gender Non-conforming
- Intersex
- Pansexual
- Transgender Male
- Cisgender (non-trans) Male
- Gender Variant
- Genderflux
- Demigender
- Non-binary
- Transgender Female
- Cisgender (non-trans) Female

- Queer
- Straight
- Questioning
- Another Identity:_____
- Decline to Answer

SYMPTOMS CHECK LIST

(Circle what best describes you currently below)

None = This symptom not present at this time
Mild = Impacts quality of life, but no significant impairment of day-to-day functioning
Moderate = Significant impact on quality of life/functioning
Sever = Profound impact on quality of life/functioning

Depressed Mood	None	Mild	Moderate	Sever
Appetite Disturbance	None	Mild	Moderate	Sever
Sleep Disturbance	None	Mild	Moderate	Sever
Fatigue/Low Energy	None	Mild	Moderate	Sever
Poor Concentration	None	Mild	Moderate	Sever
Mood Swings	None	Mild	Moderate	Sever
Agitation	None	Mild	Moderate	Sever
Elevated Mood	None	Mild	Moderate	Sever
Emotionality	None	Mild	Moderate	Sever
Irritability	None	Mild	Moderate	Sever
Social Isolation	None	Mild	Moderate	Sever
Worthlessness	None	Mild	Moderate	Sever
Panic Attacks	None	Mild	Moderate	Sever
Self-Inflicted Wounding	None	Mild	Moderate	Sever
Financial Problems	None	Mild	Moderate	Sever
Hyperactivity	None	Mild	Moderate	Sever
Delusions	None	Mild	Moderate	Sever
Hallucinations	None	Mild	Moderate	Sever
Aggressive Behaviors	None	Mild	Moderate	Sever
Bingeing/Purging	None	Mild	Moderate	Sever
Anorexia	None	Mild	Moderate	Sever
Weight Loss/Gain	None	Mild	Moderate	Sever
Hopelessness	None	Mild	Moderate	Sever
Grief	None	Mild	Moderate	Sever

Sexual Problems	None	Mild	Moderate	Sever
Phobias	None	Mild	Moderate	Sever
Paranoia	None	Mild	Moderate	Sever
Obsessions/Compulsions	None	Mild	Moderate	Sever
Difficulty making friends	None	Mild	Moderate	Sever
Difficulty keeping friends	None	Mild	Moderate	Sever

PURPOSE OF VISIT

What brings you into treatment today?

_____
_____
_____
_____

How did the issue arise?

_____
_____
_____
_____

Do you have anyone who is supportive of you? Where do you go for help?

_____
_____
_____
_____

PSYCHIATRIC HISTORY

Prior suicide attempts? Yes No
If yes, when?_____
Circumstanced that led to the attempt:_____

Have you had any prior therapy? Yes No
If yes, when and for how long?_____
What was the focus of previous treatment?_____
_____

Was it helpful? _____

Prior hospitalization for mental/emotional problems? Yes No
If yes, please describe (year/duration/reason for hospitalization):

_____

_____

_____

MEDICAL HISTORY

Are you currently taking any prescription medication? Yes No

If yes, please provide the following details (to the best of your ability):

Medication	Dose	Method	Prescriber/Physician

Are any of these medications for mental/emotional problems? Yes No

Do you have any medical conditions that may affect your treatment? Yes No

Please describe your overall health today: _____

Date of last visit to Physician:_____

Do you drink Alcohol? Yes No If yes, how much do you consume in a week?_____

Do You currently use drugs (stree, non-prescription or herbal supplements)? Yes No

If yes, please describe your drug use and how often you use: _____

_____

Name of Emergency Contact: _____Relationship:_____

Emergency Contact's Phone: _____

Employed? Yes No If yes name of employer:_____

MORE ABOUT YOU

My current gender Identity is: _____ My Sexual orientation is:_____

My Sex assigned at birth is:_____

Decline to Answer: _____

Pronouns: Circle below your pronouns

She/Her/Hers	He/Him/His	Ze/Hir/Hirs
They/Them/Theirs	No Pronoun	No Preference

Not Listed:

Self-identification is important, and we understand that we each have our own understanding of the words used to describe our own experiences. So that we can best honor your identity and experiences, please describe how you identify in the free responses box and select (as many as you want) from the list below:

Select the term(s) with which you most identify, even if the same as above:

- Agender
- Bisexual
- Asexual
- Gender Non-conforming
- Intersex
- Pansexual
- Transgender Man
- Cisgender (non-trans) Man
- Gender Variant
- Genderflux
- Demigender
- Non-binary
- Transgender Woman
- Cisgender (non-trans) Woman
- Queer
- Straight
- Questioning
- Another Identity:_____
- Decline to Answer

Is there anything else you would like us to know about you:

_____

What do you consider to be your strengths? _____

What do you like most about yourself? _____

What do you consider your weaknesses? _____