Client Intake Form

Date: **Name:** **Date of birth:**
Gender: **Marital Status:** **Place of birth:**

Contact info: **May we leave a message? (Please check)**
Cell Phone: Yes No
Email address: Yes No
Address:

Emergency contact (name, relation, phone, and address):

Insurance carrier and information:

How did you hear about me?

Current occupation:

Education History: *(Please list your highest level of education and if you've had any history of educational or occupational concerns)*

Military History- Have you ever served in the military: Yes No **If yes, continue:**
Duties/specialty: **Date of separation:**
Service connected? Yes No **Any history of disciplinary actions?** Yes ☐ No ☐

Current family and household:

Do you have children? Yes No **If yes, how many and what are their ages?**

Who lives with you?

Briefly describe your childhood and upbringing:

Medical & mental health history
Any medical conditions or chronic illnesses? Yes No **If yes, please explain:**

Have you ever experienced concerns with misusing substances? Yes No

Current Medications:

Primary care physician & phone number:

Psychiatric mental health provider or prescriber:

Have you ever been hospitalized for a mental health condition? Yes No **If yes, when and for what?**

Check any current concerns:

☐ Sleep issues	☐ Trauma	☐ Change in appetite
☐ Isolation/avoidance	☐ Grief	☐ Loss of interest in activities
☐ Nightmares	☐ Pain	☐ Restlessness
☐ Hypervigilance	☐ Relationship issues	☐ Feeling numb
☐ Depressed mood	☐ Stress	☐ Difficulty concentrating
☐ Panic attacks	☐ Worrying	☐ Fear
☐ Anxiety	☐ Hopelessness	☐ Memory problems
☐ Irritability/anger	☐ Guilt	☐ Fatigue
☐ Racing thoughts	☐ Mood swings	☐ Violence/aggression
☐ Impulsive behavior	☐ Tearfulness	☐ Repetitive behaviors/ rituals
☐ Flashbacks	☐ Financial concerns	☐ Legal concerns
☐ Difficulty trusting	☐ Issues at work/school	☐ Difficulty with responsibilities
☐ Hallucinations	☐ Domestic violence	☐ Parenting concerns

When did these concerns start and how often?

Have you ever experienced thoughts of harming or killing yourself? Yes No

Current lifestyle and wellness

Describe your current level of exercise and nutrition:

List hobbies, recreational activities, and religious/spiritual practices that interest you:

Presenting concerns: *(Please describe what you are seeking care for)*

What are your strengths?