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CLIENT INTAKE HISTORY

Basic Information

Name: _____

Date of Birth: _____ Last 4 of SSN: _____

Previous Therapy & Medications

Have you had therapy before? ☐ Yes ☐ No If yes, with whom?

_____

Are you currently taking psychiatric medication? ☐ Yes ☐ No Prescribed by:

_____

Medication(s): _____

Your Health

Primary Care Provider: _____

Last physical exam: _____

Chronic health concerns (e.g. pain, diabetes, asthma):

_____

Medications for physical health issues? ☐ Yes ☐ No

If yes, list: _____

Sleep: ☐ Sleeping too little ☐ Too much ☐ Poor quality ☐ Nightmares

Appetite/Eating: ☐ Normal ☐ Less ☐ More ☐ Bingeing ☐ Restricting

Weight change in last 2 months? ☐ Yes ☐ No

Exercise per week: _____ days

Substance Use

Alcohol use? ☐ Yes ☐ No

If yes, how often do you have 4+ drinks in 24 hours? _____

Recreational drug use: ☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely ☐ Never

Tobacco/Nicotine use? ☐ Yes ☐ No

Mood, Thoughts & Emotions

Recent suicidal thoughts? ☐ Frequently ☐ Sometimes ☐ Rarely ☐ Never

Past suicidal thoughts? ☐ Frequently ☐ Sometimes ☐ Rarely ☐ Never

Check any that apply:

☐ Depression ☐ Mood swings ☐ Anxiety ☐ Panic attacks

☐ Sleep problems ☐ Hallucinations ☐ Memory lapses ☐ Substance abuse

☐ Eating issues ☐ Obsessions or compulsions ☐ Body image problems

☐ Homicidal thoughts ☐ Suicide attempt(s) – If yes, when? _____

Significant stress/life changes in the past year? ☐ Yes ☐ No

If yes: _____

Work & Stress

Current job: _____

Satisfied with job? ☐ Yes ☐ No

Work-related stressors: _____

Spirituality

Do you consider yourself:

☐ Religious Faith: _____

☐ Spiritual (but not religious)

☐ Neither

Family Mental Health History

Check any difficulties experienced by immediate or extended family members:

Issue	Yes/No	Family Member (if known)
Depression	☐ / ☐	_____
Bipolar Disorder	☐ / ☐	_____
Anxiety/Panic Attacks	☐ / ☐	_____
Schizophrenia	☐ / ☐	_____
Substance Use Issues	☐ / ☐	_____
Eating Disorders	☐ / ☐	_____
Learning Disabilities	☐ / ☐	_____
Trauma History	☐ / ☐	_____
Suicide Attempts	☐ / ☐	_____
Chronic Illness	☐ / ☐	_____

You as a Person

What are your personal strengths?

_____

What do you like most about yourself?

_____

What coping skills have worked for you in the past?

_____

What do you hope to gain from therapy?

_____