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Psychotherapy Client Intake Form

Client Name: _____ **DOB:** _____ **Age:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Cell Phone:** _____

Email: _____

Race: ☐ Caucasian ☐ African-American ☐ Asian ☐ Latino / Hispanic ☐ Native American ☐ Multi-Racial

Gender: ☐ Female ☐ Male Other: _____

Spiritual/Religious Beliefs or Affiliations: _____

Emergency Contact: _____ **Phone:** _____

EMPLOYMENT / EDUCATION

Status:

☐ Full Time Job ☐ Part Time Job ☐ Unemployed ☐ Student ☐ Disabled ☐ Retired

Education Completed:

☐ Less Than High School ☐ High School / GED ☐ Associate's Degree

☐ Some College ☐ Bachelor's Degree ☐ Post Graduate Degree

Employer / School: _____ **Occupation / Year in School:** _____

Longest Place of Employment: _____ **Date Employed:** _____

FAMILY HISTORY

Parents' Marital Status (Check all that apply):

☐ Still Married ☐ Divorced at age: _____ ☐ Mother remarried ☐ Father remarried

☐ Father deceased at age: _____ ☐ Mother deceased at age: _____ ☐ Raised By Relatives ☐ Raised by Foster Parent

Home Environment Growing Up:

☐ Normal / Good ☐ Chaotic ☐ Witnessed Abuse ☐ Experienced Abuse

Please elaborate on or describe any special circumstances during your childhood: _____

_____

_____

Relationship Status:

☐ Single ☐ In a relationship _____ years ☐ Engaged _____ years

☐ Married _____ years ☐ Divorced _____ years ☐ Widowed _____ years

Relationship / Relationship Status Satisfaction:

☐ Very Satisfied ☐ Satisfied ☐ Neutral ☐ Dissatisfied ☐ Very Dissatisfied

_____

_____

Describe your current living situation: _____

_____

If you have kids, list their names, ages, and primary residence: _____

_____

LEGAL HISTORY

Check off any current or past legal concerns:

☐ Driving Offenses ☐ Financial ☐ Spousal / Custody ☐ Violence ☐ Immigration ☐ Substance Use

Have you previously been imprisoned? ☐ Yes ☐ No

If yes, please explain: _____

_____

MEDICAL HISTORY

Primary Care Physician: _____ **Phone Number:** _____

Psychiatrist: _____ **Phone Number:** _____

Serious Medical Illnesses / Accidents (Identify and give dates): _____

_____

Are you currently on any medications? ☐ Yes ☐ No

If yes, please list dosage and condition it is treating: _____

_____

Have you previously been hospitalized? ☐ Yes ☐ No

If yes, please describe: _____

_____

Have you been the victim of physical or sexual abuse?	☐ Yes	☐ No	If yes, describe:
Do you or have you had suicidal thoughts?	☐ Yes	☐ No	If yes, describe:
Have you attempted suicide?	☐ Yes	☐ No	If yes, when?
Do you or have you had an eating disorder?	☐ Yes	☐ No	If yes, describe:
Have you previously been treated for substance abuse?	☐ Yes	☐ No	If yes, when?
Have you previously been to counseling?	☐ Yes	☐ No	If yes, when?

Please check off all items that are of concern to you:

☐ Alcohol / Drug Problem	☐ Anger	☐ Anxiety, Nervousness
☐ Depression	☐ Eating / Appetite Problem	☐ Family Conflict
☐ Friendship Conflict	☐ Health Problem	☐ Loneliness
☐ Money / Financial Problem	☐ Parent - Child Problem	☐ Procrastination / Motivation
☐ Relationship / Marital Problem	☐ Self-Control	☐ Self-Esteem
☐ Sexual Concerns	☐ Shyness	☐ Sleep Problem
☐ Spiritual / Existential Problem	☐ Stress	☐ Suicidal Thoughts / Behaviors
☐ Traumatic Experience	☐ Work / Career Concerns	☐ Other:

Describe the main concern that brings you here: _____

_____

_____

_____

Is there anything else you would like to share? _____

_____

_____

_____

_____