Adult Intake Form

Client Name:_____ Date of Birth:_____

*Please provide the following information **prior to your initial session** and either return it to us via email or bring it with you to the first session. Leave blank any question you would rather not answer, or would prefer to discuss with your therapist. Information you provide here is held to the same standards of confidentiality as our therapy.*

Treatment History

Are you currently receiving psychiatric services, professional counseling, or psychotherapy elsewhere? ◯ yes ◯ no

Have you had previous psychotherapy?
◯ no
◯ yes, with (previous therapist's name)_____

Are you currently taking prescribed psychiatric medication (antidepressants or others)?
◯ yes ◯ no

If yes, please list: _____

Prescribed by: _____

Health and social information

Do you currently have a primary physician? ◯ yes ◯ no

If yes, who is it? _____

Are you currently seeing more than one medical health specialist? ◯ yes ◯ no

If yes, please list: _____

When was your last physical? _____

Please list any current or persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.:

_____
_____
_____

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Are you currently on medication to manage a physical health concern? If yes, please list:

_____

_____

_____

Are you having any problems with your sleep habits? ◯ yes ◯ no

If yes, check where applicable:

☐ Sleeping too little ☐ Sleeping too much ☐ Poor quality sleep

☐ Disturbing dreams ☐ other _____

How many times per week do you exercise? ____ Approximately how long each time? ___

Are you having any difficulty with appetite or eating habits? ◯ no ◯ yes

If yes, check where applicable: ☐ Eating less ☐ Eating more ☐ Bingeing ☐ Restricting

Have you experienced significant weight change in the last 2 months? ◯ no ◯ yes

Alcohol and Drug Use

Do you regularly use alcohol? ◯ no ◯ yes

In a typical month, how often do you have 4 or more drinks in a 24 hour period? _____

How often do you engage recreational drug use? ◯ daily ◯ weekly ◯ monthly ◯ rarely ◯ never

Which drugs do you use recreationally?_____

_____

Do you smoke cigarettes, vape or use other tobacco products? ◯ yes ◯ no

Relationships

How do you identify your sexual orientation? ☐ Heterosexual ☐ Homosexual ☐ Bisexual ☐ Pansexual ☐ Asexual ☐ Other _____

What are the proper pronouns you would like us to use?_____

Are you currently in a romantic relationship? ◯ no ◯ yes

If yes, for how long? _____

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What is your preferred style of romantic relationship? ☐ Monogamous ☐ Polyamorous ☐ Ethical Non-Monogamy ☐ Other_____

What are your partner(s) name(s)? _____

On a scale of 1-10 (10 being the highest quality), how would you rate your current relationship? _____

What is the reason you gave this score?

_____
_____
_____

Mental Wellbeing

In the last year, have you experienced any significant life changes or stressors? If yes, please explain:

_____
_____
_____

Have you ever experienced any of the following?

	Yes	No	Date of Last Incidence
Extreme depressed mood	◯	◯	
Dramatic mood swings	◯	◯	
Rapid speech	◯	◯	
Extreme anxiety	◯	◯	
Panic attacks	◯	◯	
Phobias	◯	◯	
Sleep disturbances	◯	◯	
Hallucinations	◯	◯	
Unexplained losses of time	◯	◯	
Unexplained memory lapses	◯	◯	
Alcohol/substance abuse	◯	◯	
Frequent body complaints	◯	◯	
Eating disorder	◯	◯	
Body image problems	◯	◯	
Repetitive thoughts (e.g. obsessions)	◯	◯	
Repetitive behaviors (e.g. frequent checking, hand washing	◯	◯	
Homicidal thoughts	◯	◯	
Suicidal attempts	◯	◯	

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Have you ever had suicidal thoughts? ◯ yes ◯ no
If yes, how often do they occur?_____
If yes, when was the last time you had them? _____
Have you ever *intentionally* caused harm to yourself? ◯ yes ◯ no
If yes, how often do they occur?_____
If yes, when was the last time you had them? _____

Do you feel you have experienced any significant traumas (however YOU define trauma) in your life to this point? ◯ no ◯ yes
If you feel comfortable doing so, please elaborate:
_____
_____
_____
_____
_____
_____

Occupational information

Are you currently employed? ◯ no ◯ yes

If yes, who is your currently employer/position? _____

If yes, are you happy with your current position? ◯ no ◯ yes

Please list any work-related stressors, if any
_____
_____
_____

Religious/spiritual information

Do you consider yourself to be religious / spiritual? ◯ no ◯ yes

If yes, what is your faith / spirituality? _____

Do you have any religious or spiritual practices that you would like us to know about?
_____
_____
_____

How would you describe the importance that your faith / spirituality has in your life?
_____
_____
_____

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Family mental health history

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following?

Difficulty	Yes	No	Relation	Was the issue diagnosed?
Depression	○	○		
Bipolar disorder	○	○		
Anxiety disorder	○	○		
Panic attacks	○	○		
Schizophrenia	○	○		
Alcohol/substance abuse	○	○		
Eating disorders	○	○		
Learning disabilities	○	○		
Trauma history	○	○		
Suicide attempts	○	○		
Chronic illness	○	○		

Other information

What do you consider to be your strengths?

_____

_____

What are your hobbies?

_____

_____

What do you like most about yourself?

_____

_____

What are effective coping strategies that you have learned?

_____

_____

What are your goals for therapy?

_____

_____

_____

_____