CLIENT INTAKE FORM

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Therapy for Individuals, Couples, Children & Families
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Please fill out this form and bring it to your first session.
Please note: *information you provide here is protected as confidential information.*

Name: ____
(Last) (First) (Middle Initial)

Name of parent/guardian (if under 18 years):
____
(Last) (First) (Middle Initial)

________________________ ________________________
Home Phone Cell/Other Phone
May we leave a message? □ Yes □ No May we leave a message? □ Yes □ No

Address: ____
(City) (State) (Zip)

E-mail: ________________________________ May we email you? □ Yes □ No
*Please note: Email correspondence is not considered to be a confidential medium of communication.

Birth Date: ______ /______ /______ Age today: ________ Gender: □ Male □ Female
Marital Status:
□ Never Married □ Domestic Partnership □ Married □Separated □Divorced □Widowed

Please list any children/age: ____
____

Referred by (if any): ____
____

How did you hear about us?: ____

Please briefly describe why you are seeking counseling right now: ____________________
____
____

Current reason for seeking services:
Individual Counseling/Therapy
Couples Counseling/Therapy: Partner name & age: ________________________
Family Counseling/Therapy : Family member names & ages: ________________________
____

____

Have you previously received any type of mental health services? □ No □ Yes,
If yes, previous therapist/counselor and location: ____

____

Are you currently taking any prescription medication? □ Yes □ No
Please list: ____

____

Have you ever been prescribed psychiatric medication?
□ Yes □ No Please list :____

Please list any over-the-counter medications, herbs, supplements, etc.:_________________________

____

How would you rate your current social support network: (friends, family & pets you have good relationships with)
Poor Unsatisfactory Satisfactory Good Very good

How connected do you feel to your current community? On a scale of 1 – 5 ____________
1. Not at all 2. A little 3. moderately 4. good connections 5. high level of connection

GENERAL HEALTH QUESTIONS

Who is your physician?____

How would you rate your current physical health? (please circle)
Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:
____
____

How would you rate your current sleeping habits? (please circle)
Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing: _______________________
____

How many times per week do you generally exercise? ________ for how long?____________________

What types of exercise to you participate in? ____
____

Please list any difficulties you experience with your appetite or eating patterns:
____
____

Are you currently experiencing overwhelming sadness, grief, or depression?

□ No □ Yes If yes, for approximately how long? ____

Are you currently experiencing anxiety, panic attacks, or have any phobias? □ No □ Yes
If yes, when did you begin experiencing this? ____

Are you currently experiencing any chronic pain? □ No □ Yes
If yes, please describe: ____

Do you drink alcohol more than twice a week? □ No □ Yes □ Infrequently □ Never
Do you think you may have a problem with alcohol? yes/no/maybe
How often do you engage recreational drug use?
Substance(s) ____

□ Daily □ Weekly □ Monthly

Do you use tobacco products? yes/no

Are you currently in a romantic relationship? yes/no/it's complicated
If yes, for how long? ____
On a scale of 1-10 (1= extremely negative 10= extremely positive) please rate your current relationship? ____

What significant life changes or stressful events have you experienced recently: ____________________

____

____

Have you been or are are you currently in the military? yes/no
If yes, please describe types service & dates:
____
____

Have you been deployed to combat settings? yes/no
If yes, where ____________________________ when _____________ to _____________
where ____________________________ when _____________ to _____________
where ____________________________ when _____________ to _____________

FAMILY MENTAL HEALTH HISTORY:
In the section below, identify if there is a family history of any of the following.
If yes, please indicate the family member’s relationship to you in the space provided (father, grandmother, uncle, etc.)

Please Circle and List Family Member(s)
Alcohol/Substance Abuse yes/no ___________________
Anxiety Depression yes/no___________________
Domestic Violence yes/no ___________________
Eating Disorders yes/no ___________________
Obesity yes/no ___________________
Obsessive Compulsive Behavior yes/no ___________________
Schizophrenia yes/no ___________________
Suicide Attempts yes/no ___________________

Are your problems affecting any of the following: (circle)
daily tasks work/school leisure activities self-esteem legal matters health relationships
housing hygiene finances sexual activity concentration

ADDITIONAL INFORMATION:
Are you currently employed □ No □ Yes If yes, what is your current employment situation?
____

Do you enjoy your work? _____________Is your current work excessively stressful? _____________
____

Do you consider yourself to be spiritual or religious? □ No □ Yes
If yes, describe your faith or belief: ____
____
____

What do you consider to be some of your successes/strengths?
____
____

What do you consider to be the barriers to your happiness right now?
____
____

What would you like to accomplish with counseling?
____
____

Describe how your life will be different when you accomplish your therapeutic goals:
____
____

Do have any concerns about seeking therapy? yes/no If yes, please explain:
____
____
____

Other important information
____
____

____
____
____
____
____
____

Emergency Contact Person

Name _______________________________________ Relationship _____________________

Phone(s)______________________________   _______________________________

Address:____

Primary Care Physician _______________________________ phone _____________________

___________________________________   _______________
Signature   Date