CLIENT INTAKE FORM

Please answer the following questions to the best of your ability. These questions are intended to help the clinician with the therapy process. All information is completely confidential.

Client Information

Name: ____

(Last) (First) (Middle Initial)

Current Address:

____

Name of parent or guardian (if minor):

____

Birth Date: ____/____/____ Age: ___ Gender: □ Male □ Female

Marital Status: □ Never married □ Partnered □ Married □ Separated □ Divorced □ Widowed

Emergency Contact: _____________________________________ Phone: __________________

Cell/other: _________________________________ Home: _____________________________

Email: ____________________________________

May I leave a text message? □ Yes □ No

May I leave a phone message? □ Yes □ No

May I email you? □ Yes □ No

Referred by: ____

Are you currently receiving psychological services, professional counseling, psychiatric services, or any other mental health services? □ Yes □ No

Reason for Change: ____

____

Have you had any mental health services or hospitalization in the past? □ Yes □ No

Reason: ____

Are you currently taking any psychiatric prescription medications? □ Yes □ No Please list the medications you are currently taking: ____

____

____

General Health and Mental Health Information

How is your physical health at the present time?
□ Poor □ Unsatisfactory □ Satisfactory □ Good □ Very good
Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, thyroid dysfunction, etc.): ____________________________________

____

Are you on any medication for physical/medical issues? □ Yes □ No
Please list all other medications and dosages ____

____

____

Are you having any problems with your sleep habits? □ Yes □ No
If yes, check which applies: □ Sleep too much □ Sleep too little □ Poor quality □ Disturbing dreams Other:

____

____

How many times per week do you exercise? ______Days ______Minutes ______Hours

Are there any changes or difficulties with your eating habits? □ Yes □ No If yes: □ Eating less □ Eating more □ Binging

Have you experienced a weight change in the last two months? □ Yes □ No □ Restricting

Do you consume alcohol regularly? □ Yes □ No
In one month, how many times do you have 4 or more drinks in a 24-hour period? ___________

How often do you engage in recreational drug use?

□ Daily □ Weekly □ Monthly □ Rarely □ Never

Which drugs? ____

Have you felt depressed recently? □ Yes □ No If yes, for how long? ______________________

Have you had any suicidal thoughts recently? □ Yes □ No If yes: □ Frequently □ Sometimes

Have you had suicidal thoughts in your past? □ Yes □ No If yes, how long ago? _____ How often? _______

Are you currently in a romantic relationship? □ Yes □ No

If yes, how long have you been in this relationship? _____________________________________

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

____

In the last year, have you had any major life changes (e.g. new job, new home, illness, relationship change, etc.)?

____

____

____

Occupational Information

Are you currently employed? □ Yes □ No

If yes, who is your employer? ___________________________ What is your position? ______

____

Are you happy in your current position? □ Yes □ No

Are you fulfilled in your current position? □ Yes □ No

Does your work make you stressed? □ Yes □ No

If yes, what are your related stressors?

____

Quick Check

Check the boxes of the symptoms you have experienced within the last year.

□ Extreme depressed mood

□ Panic attacks

□ Memory lapse

□ Repetitive thoughts

□ Homicidal thoughts

□ Mood swings

□ Phobias

□ Alcohol/substance abuse

□ Anxiety

□ Suicide attempts

□ Rapid speech

□ Disturbed sleep

□ Body complaints

Other: ____

Religious/Spiritual Information

Do you practice a religion? □ Yes □ No If yes, what is your faith? ___________________________

________________________________ If no, do you consider yourself to be spiritual? □ Yes □ No

Family Mental Health History

The following is to provide information about your family history. Please, mark each as yes or no. If yes, please indicate the family member affected.

Depression: □ Yes □No

Anxiety Disorder: □ Yes □No

Bipolar Disorder: □ Yes □No

Panic Attacks Alcohol/Substance Abuse Eating Disorder: □ Yes □No

Learning Disability: □ Yes □No

Trauma History: □ Yes □No

Domestic Violence: □ Yes □No

Obesity: □ Yes □No

Obsessive Compulsive Behavior: □ Yes □No

Schizophrenia: □ Yes □No

Family Member:

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

Other Information

List your strengths.

____

____

List areas you feel you need to develop.

____

____

What do you like most about yourself?

____

____

What are some ways you cope with obstacles and stress?

____

____

____

What are your goals for therapy? What would you like to accomplish?

____

____