Client Intake Form

Please complete this form for our records and bring it with you to our first appointment.
The information you provide in this form is protected and confidential.

First Name: Last Name:

Date of Birth: Age: Gender:

Relationship Status:

If any children, please list names and ages:

Mobile or Home Phone:

Is it ok to leave a message for you at this number? O Yes O No

Work Phone:

Is it ok to leave a message for you at this number? O Yes O No

Street Address:

City: State: Zip:

Email Address:

Current Employer:

Position:

Employment Status: O F/T O P/T O Self-employed O Returning to work O P/T O Other

How long have you been on this job?

Do you enjoy your job?

Education Level:

Special Trainings:

Hobbies:

Talents:

Military Background:

Emergency Contact Name: Phone:

Relationship to You:

How were you referred?

If online, by which website?

Physical & Mental Health

How would you describe your physical health? O Excellent O Good O Average O Poor

Do you have any current concerns about your physical health? If yes, please describe:

Please describe any recent major illnesses or surgeries:

Are you currently under a doctor's care? O Yes O No

If yes, name of doctor:

Reason for doctor's care:

Are you currently taking medications? O Yes O No

If yes, list name of medications and reason for taking:

Who prescribed your current medication?

If you've been hospitalized, please describe the reason(s):

Have you ever been hospitalized for a mental illness? O Yes O No

If yes, please describe:

Have you had suicidal thoughts recently? O Yes O No

If yes, how often? O Frequently O Occasionally O Rarely

Have you had suicidal thoughts in the past? O Yes O No

If yes, how often? O Frequently O Occasionally O Rarely

Have you ever suffered from an eating disorder, such as obesity, anorexia, or bulimia?

Have you experienced a significant weight change within the last 3 months?

Do you have any other persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.)? Please list:

Are you experiencing any trouble sleeping or with sleep habits? O Yes O No

If yes, please describe:

Physical & Mental Health (Cont.)

How often do you exercise?

Approx. how many minutes each time?

Alcohol & Drug Use History

Do you regularly use alcohol?

In an average month, how often do you have 4 or more drinks in a single 24hr. period?

Do you engage in recreational drug use? ○ Yes ○ No

If yes, how often? ○ Daily ○ Weekly ○ Monthly

Please check all of the drugs you use currently or have used in the past:

- ☐ Amphetamines
- ☐ Cocaine/Crack
- ☐ Marijuana
- ☐ Opiates
- ☐ Barbiturates
- ☐ Hallucinogens
- ☐ Methamphetamines
- ☐ Other

Relationships & Family

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

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

On a scale of 1-10, how would you rate the quality of this current relationship?

Has anyone in your family experienced or struggled with any of the following? Please circle all that apply, and note the family member's relationship to you (e.g. "sibling", "aunt", etc.)

	Relationship	Comments
☐ Abuse Issues		
☐ ADHD/ADD		
☐ Alcohol abuse		
☐ Anxiety disorder		
☐ Asperger's/Autism		
☐ Bipolar disorder		
☐ Depression		
☐ Drug/other substance abuse		
☐ Eating disorder		
☐ Epilepsy/Seizures		
☐ Learning disability		

Relationships & Family (Cont.)

	Relationship	Comments
☐ Panic attacks		
☐ Psychosis		
☐ Schizophrenia		
☐ Suicide attempts		
☐ Traumatic history		

Additional Information

What sort of things do you enjoy doing in your free time?

What do you like most about yourself?

What are your goals for therapy?

Current Concerns

Please fill in circles:

I am experiencing:	Low	Moderate	Severe
Sadness	O	O	O
Anxiety/Fear	O	O	O
Elevated Mood	O	O	O
Irritability Anger/temper problems	O	O	O
Reasoning/Judgment Problems	O	O	O
Concentration Problems	O	O	O
Memory Problems	O	O	O
Energy Level Problems	O	O	O
Appetite problems	O	O	O
Sleep problems	O	O	O
Other:	O	O	O