Client Intake Form

Please provide the following information for my records. If you prefer not answer a certain question, feel free to leave it blank. Information you provide here is held to the same standards of confidentiality as our therapy. Please print this form and bring it to your first session.

Name: _____

Name of parent/guardian (if you are a minor): _____

Birth date: _____ Age: _____

Gender: ○ Male ○ Female

Relationship status: ○ Single ○ Partnered ○ Married ○ Separated ○ Divorced ○ Widowed

Number of children: _____

Local address: _____

Home phone: _____ May I leave a message? ○ Yes ○ No

Cell phone: _____ May I leave a message? ○ Yes ○ No

E-mail address: _____ May I email you? ○ Yes ○ No

Referred by: _____

Are you currently receiving psychiatric services or therapeutic services elsewhere? ○ Yes ○ No

Have you had previous therapy? ○ Yes ○ No

Are you currently taking any prescribed psychiatric medications? ○ Yes ○ No

If yes, please list: _____

Health and Social Information

How is your physical health at present?

○ Poor ○ Unsatisfactory ○ Satisfactory ○ Very good ○ Excellent

Please list any chronic or persistent physical symptoms or health concerns:

_____

_____

Are you having any problems sleeping? ○ Yes ○ No

If yes, please describe: _____

_____

Are you having any difficulties with your appetite/eating habits? ○ Yes ○ No

If yes, please describe: _____

_____

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Have you had any suicidal thoughts recently? ○ Never ○ Rarely ○ Sometimes ○ Frequently

Have you had suicidal thoughts in the past? ○ Never ○ Rarely ○ Sometimes ○ Frequently

Have you ever experienced the following?

Extreme depressed mood: ○ Yes ○ No

Extreme mood swings: ○ Yes ○ No

Rapid speech: ○ Yes ○ No

Extreme anxiety: ○ Yes ○ No

Panic attacks: ○ Yes ○ No

Phobias: ○ Yes ○ No

Sleep disturbances: ○ Yes ○ No

Hallucinations: ○ Yes ○ No

Unexplained memory loss: ○ Yes ○ No

Alcohol/substance abuse: ○ Yes ○ No

Eating disorder: ○ Yes ○ No

Body image problems: ○ Yes ○ No

Repetitive thoughts (constant ruminations, obsessions): ○ Yes ○ No

Repetitive behaviors (frequent hand washing, checking): ○ Yes ○ No

Homicidal thoughts: ○ Yes ○ No

Suicide attempt: ○ Yes ○ No

Occupational Information

Are you currently employed? ○ Yes ○ No

If yes, who is your current employer? _____

What is your current position? _____

Are you satisfied/happy with this position? _____

_____

Please list any work related stressors: _____

_____

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Religious/Spirituality Information

Do you consider yourself to be religious? ○ Yes ○ No

If yes, what is your faith? _____

Do you consider yourself to be spiritual? ○ Yes ○ No

Family Mental Health Information

Has anyone in your family experienced difficulties with the following? Please list the family member that experienced the difficulties, such as sister, uncle, grandmother, etc.

Depression: ..... ○ Yes ○ No _____

Bipolar Disorder: ..... ○ Yes ○ No _____

Anxiety Disorders ..... ○ Yes ○ No _____

Panic Attacks: ..... ○ Yes ○ No _____

Schizophrenia: ..... ○ Yes ○ No _____

Alcohol/Substance Abuse: .... ○ Yes ○ No _____

Eating Disorders: ..... ○ Yes ○ No _____

Trauma History: ..... ○ Yes ○ No _____

Suicide Attempts: ..... ○ Yes ○ No _____

What do you consider to be your strengths? _____

_____

_____

What do you like most about yourself? _____

_____

_____

If you could have any super power, what would it be and why? _____

_____

_____

Thank you for taking the time to fill out this form.

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