CLIENT INTAKE FORM

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Your name: _____ Today's Date: _____

Address: _____

Email address: _____ Age _____ Sex _____

Cell Phone: _____ Home Phone: _____

Preferred method of contact: Email ___ Phone ___ Text ___ OK to leave private messages? Y ___ N ___

Emergency Contact (Name, best contact phone number, relationship): _____

_____

Please take your time in providing the following information. The questions are designed to help me begin to understand you so that our time together can be as productive as possible. All information provided will be treated as confidential. PLEASE TYPE OR WRITE ANSWERS ON THIS DOCUMENT. Feel free to elaborate by using the back of this form or an extra page online.

What is your reason for seeking my services? _____

_____

_____

_____

Have you experienced any significant life changes or stressful events recently?_____

_____

_____

What is your general stress level, on a scale of 1 – 10, with 1 being the lowest? ____

What do you typically do to manage stress? _____

Have you experienced any physically or emotionally traumatic events, accidents, surgeries, significant health issues, loss of good friend or loved one, etc. during your adult years? Please specify.

_____

_____

_____

Are you aware of any troubling experiences from your infancy, childhood, or teenager years? Include major and relatively minor events (*i.e.,* physical, emotional, or sexual abuse, keeping a significant secret, not being heard or not being able to speak up, being bullied, losing a best friend, a close family member, or a close pet, suicide of a family member or friend, hospitalizations, accident, serious illnesses, alcoholism in the family, birth trauma such as being premature or spending time in an incubator, etc.). _____

_____

_____

_____

What childhood events (physical, emotional, cognitive, spiritual) may have contributed to who you are now?

_____

_____

Health

Have you ever or are you currently experiencing any of the following health conditions?

Migraine headaches ___ Chronic pain ___ Chronic fatigue ___ Fibromyalgia ___ Premenstrual pain/cramps that are debilitating ___ Irritable bowel syndrome ___ Crohn's ___ Other forms of persistent gastrointestinal distress ___ Severe allergies ___ Autoimmune illness (MS, ALS, other?) ___ Cancer ___ High blood pressure ___	Heart disease ___ Depression ___ Anxiety ___ Panic attacks ___ Phobias ___ OCD ___ Other diagnosed mental illness ___ Thyroid issues ___ Rheumatoid arthritis ___ Chronic skin conditions (eczema, psoriasis, etc.) ___ Teeth grinding ___

Other health problems: _____

Is there anything else you'd like me to know about your health? _____

How would you rate your sleeping habits?

Poor ___ Unsatisfactory ___ Satisfactory ___ Good ___ Very Good ___

If you are having problems, in which phase of sleep are you experiencing issues?

Falling asleep ___ Staying asleep ___ Awakening too early ___

Do you have frequent nightmares? Yes ___ No ___

Please list any other sleep problems you are currently experiencing: _____

_____

How many times per week, if any, do you generally exercise? _____

Please describe current and previous use of alcohol or recreational drugs: _____

_____

Please list any current psychiatric medications:

Medication	Dosage	Condition

Rate your general energy level on a scale of 1–10, with 1 being very low and 10 being very high: _____

How would you rate your physical health?

Poor ___ Unsatisfactory ___ Satisfactory ___ Good ___ Very Good ___

Please describe any current symptoms and their frequency. Note times of day/night when you feel worse, and any patterns you notice around what may trigger you (stress, emotional upset, lack of sleep, eating certain foods, environments, exercise, family, relationships, etc.): _____

_____

_____

Anxiety: On a scale of 1 – 10, with 1 being the lowest, rate your ability to regulate nervous system. ____

Mood: On a scale of 1 – 10, with 1 being the lowest, rate your mood. ____

Are you currently receiving any type of mental health services? Yes ___ No ___

If yes, then which of the following: Psychotherapy ____ Medication ____

Name of provider or facility: _____

Location: _____

Approximate beginning date of treatment: _____

Reason for treatment: _____

Provide a summary of previous mental health services, including psychotherapy, inpatient or outpatient hospitalizations and approximate months/years of treatment. _____

_____

_____

Do you believe any services helpful? Were any services not helpful? _____

_____

Family History

Please list parents and siblings. Use additional pages as needed.

Name	Age	Relationship	Whether they are living or deceased, how would you describe your relationship?

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, brother, etc.)

Condition	Yes or No	List Family Member
Alcohol/Substance Abuse		
Anxiety		
Depression		

Domestic Violence		
Sexual Abuse		
Eating Disorders		
Obsessive Compulsive Disorder		
Schizophrenia		
Suicide Attempts		
Other diagnosed mental health condition?		

With whom did you live while growing up? _____

What did it feel like to grow up in this family? _____

Your Marital Status: (Please Mark "X")
Never Married ___ Domestic Partner ___ Married ___ Separated ___ Divorced: For how long? ____
Widowed: Please provide your partner's name and year deceased: _____

If currently married, how long have you been married? _____ Partner's name _____

On a scale of 1-10 (best), how would you rate your relationship? _____

Please list any **children**:

Name	Age	Comments

Additional Information

Are you employed? Yes __ No __ If yes, what is your occupation? _____

What do you enjoy about your work? If retired, are you enjoying your life?

Do you have any wish to change your job or profession?

What do you enjoy doing in your free time? What do you do to relax?

Do you have any mind/body practice like yoga, meditation, tai chi, art, writing, time in nature, etc.? Please specify.

What aspects of your life are going well, are sources of joy?

Do you consider yourself to be spiritual or religious? If so, briefly describe:

Do you have a social and/or familial support network (friends, family, spouse, church group, etc.)?

How satisfied are you with your home life? (On a scale of 1–10, 1 being very low and 10 being extremely high.) ___
Comments:

Do you have any animals in your life?

What do you consider to be some of your strengths?

What do you consider your areas that need growth?

Do you hold any identities that seem relevant to our work together? (race, gender, sexual orientation, class, ability, profession, etc.)

Is there anything else you'd like me to know that would help me best support you?