

CLIENT INTAKE FORM

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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 is confidential.

Date of first appointment:_____

GENERAL INFORMATION:

Last Name:_____First Name:_____Middle:_____

Birth Date:_____Age:_____Gender: ☐ Male ☐ Female

Address: _____

(Street and Number)

(City, State, & Zip)

Employer:_____Profession/Vocation:_____

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Home Phone:_____May I leave a message? ☐ Yes ☐ No

Cell Phone:_____May I leave a message? ☐ Yes ☐ No

Email:_____May I email you? ☐ Yes* ☐ No

*Please note: Email communication is not considered to be a confidential form of communication.

Emergency Contact:_____Telephone:_____

Relationship to You:_____

Referred by:

☐ Medical Provider:_____

☐ Insurance Provider:_____

☐ My Website

☐ Psychology Today:_____

☐ Friend/Family:_____

☐ Other:_____

Referred By:_____

May I thank the person? ☐ Yes ☐ No If yes, please give the contact information:_____

Have you previously received any type of mental health services?

☐ Yes

☐ No

If yes, which of the following:

☐ Psychotherapy

☐ Medication

☐ Outpatient Hospitalizations

☐ Inpatient Hospitalizations

If yes, please provide:

Name of provider or facility:_____

Location:_____

Dates of treatment:_____

Reason for treatment:_____

Briefly, what brings you in today?

When did your issue first start? Within the last:

☐ 30 days

☐ 6-12 months

☐ 2 years

☐ During adolescence

☐ During childhood

What areas of your life have been affected because of this issue?

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

☐ Yes

☐ No

If yes, for approximately how long?_____

Are you currently experiencing anxiety, panic attacks, or any phobias?

☐ Yes

☐ No

If yes, what exactly are you experiencing and when did you begin experiencing this?

Please describe any major losses or traumas you have experienced.

What significant life changes or stressful events have you experienced recently?

What would you like to accomplish out of your time in therapy?

Family History

Where were you born?_____

Where did you grow up?

☐City

☐Suburbs

☐Country

Please list your parents and siblings. Please use additional space on the back if needed.

Name Age Relationship Where do they live? If deceased, age and cause of death

Who did you live with while growing up?_____

Mother's occupation:_____

Father's occupation:_____

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.).

Condition	Please Circle	List Family Member
Alcohol/Substance Abuse	yes/no	
Anxiety	yes/no	
Depression	yes/no	
Domestic Violence	yes/no	
Sexual Abuse	yes/no	
Eating Disorders	yes/no	
Obesity	yes/no	
Obsessive Compulsive Disorder	yes/no	
Schizophrenia	yes/no	
Suicide Attempts	yes/no	
Other diagnosed mental health condition?		
What was the diagnosis?(if yes)-_____		

Marital Status:

☐ Never married

☐ Domestic Partner

☐ Married

☐ Separated

☐ Divorced (how long?) _____

☐ Widowed: Please provide partner's name and year deceased. _____

If married, how long have you been married and what is your partner's name?

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

Are you currently in a romantic relationship?

☐ Yes- How long? _____

☐ No

Please list any children, their names, and ages:

Name	Age	Relationship	Name of other parent	If deceased, age and cause
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Physical Health

Please list any medications, herbs, or supplements you take. Be sure to include the condition, as some medications are prescribed for off-label use. Continue on the back if needed, or provide a separate list. If you have a complicated medical profile, please supply supporting documentation to be able to facilitate a comprehensive understanding of your health.

Medication/Supplement	Dosage	Condition	Date Began/Stopped
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Prescribing provider and contact information:

Name: _____

Specialty: _____

Facility: _____

Phone, email, or fax: _____

How would you rate your current physical health?

- ☐ Poor
- ☐ Unsatisfactory
- ☐ Satisfactory
- ☐ Good
- ☐ Very Good

Please list any health problems you are currently experiencing:

How would you rate your current 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 early
- ☐ Sleep apnea

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

How many times per week do you generally exercise?

How long do you exercise?

What type(s) of exercise do you participate in?

Are you currently experiencing any chronic pain?

☐ Yes

☐ No

If yes, please describe:

Please describe current use of alcohol, cigarettes, and/or recreational drugs:

Please describe previous use of alcohol, cigarettes, and/or recreational drugs.

Additional Information

What do you enjoy about your work (full-time homemaker included)? If retired, what did you enjoy about your work?

What do you find particularly stressful about your current or previous work?

What do you enjoy doing in your free time?

What do you do to relax?

Do you consider yourself to be spiritual or religious? If yes, please describe your faith or belief:

What do you consider to be one of your strengths?

What do you consider to be some of your weaknesses?