CLIENT INTAKE FORM

Please provide the following information for our records. Leave blank any question you would rather not answer. Information you provide here is held to the same standards of confidentiality as our therapy. Please bring this form to your first session or allow yourself thirty minutes prior to your appointment to complete the form in our office.

Name: (Last) _____ (First) _____ (M.I.) _____

Name of parent/guardian (if you are a minor):
(Last)_____(First)_____(M.I.)_____

Birth Date: ___/_____/____ Age: _____ Gender: ____ Male _____Female

Marital Status:
__Never Married __Partnered ___Married ___Separated ___Divorced ___Widowed

Number of Children: _____

Local Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ May we leave a message? ____Yes ____No

Cell/other phone:_ _____May we leave a message? ____Yes ____No

Email: _____ May we email you? ____Yes ____No
*Please be aware that email might not be confidential.

Please describe the issue(s) that you want help with:
_____
_____
_____

How has this issue affected your life in the following areas:

Family: _____

Work: _____

Social: _____

Recreational: _____

Health: _____

How long have you had this issue: _____

Please list any important events in your life that may relate to this issue:
_____
_____
_____

What have you tried to do to solve this issue?
_____
_____
_____

What has been successful?
_____
_____
_____

PREVIOUS PSYCHIATRIC/COUNSELING SERVICES

Are you currently receiving psychiatric services, professional counseling or psychotherapy elsewhere?
____No ___ Yes, current provider's name:_____

Have you had previous counseling/psychotherapy?
____No ____Yes, at previous provider's name:_____

If yes, what was helpful about the counseling/psychotherapy?
_____

If yes, what was *not* helpful about the counseling/psychotherapy?
_____

Please list any prescribed psychiatric medication you are *currently* taking (antidepressants or others)?
_____

Please list any *previously* prescribed psychiatric medication?
_____

HEALTH AND SOCIAL INFORMATION

1. How is your physical health at present? (please circle)

   Poor Unsatisfactory Satisfactory Good Very Good

2. When was your last physical? _____

3. Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.):
   _____

4. Are you having any problems with your sleep habits? ____No ____Yes
   If yes, circle where applicable:

   Sleeping to little Sleeping to much Poor quality sleep Disturbing dreams

   Other: _____

5. How many times per week do you exercise? _____

   Approximately how long each time? _____

6. Are you having any difficulty with appetite or eating habits? ____No ____Yes

   If yes, circle where applicable: Eating less Eating more Binging Restricting

   Have you experienced significant weight change in the last 2 months? ____No ____Yes

7. Do you currently drink alcohol (i.e. beer, wine, liquor)? ____No ____Yes

   In a typical week, how often and how much do you drink? _____

8. Do you currently engage in recreational drug use?

   ____Daily ____Weekly ____Monthly _____Rarely ____Never

If so, please list which recreational drugs you use:

_____

9. Have you ever received treatment for alcohol/drug abuse? ____No ____Yes

10. Have you ever lost a job/relationship due to the usage of alcohol/drugs?

____No ____Yes

11. Are you currently involved in a romantic relationship? ____No ____Yes

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

On a scale of 1 -10 (1 being poor, 10 being excellent), how would you rate the quality of your current relationship? _____

12. Please indicate any of the following that apply to you:

Current	Past	
_____	_____	Thoughts of suicide
_____	_____	Plan for suicide
_____	_____	Suicide attempt
_____	_____	Hurting/cutting yourself deliberately
_____	_____	Thoughts of hurting someone else

13. In the last year, have you experienced any significant life changes or stressors:

(Please explain)

_____
_____
_____

Have you ever experienced:

Extreme depressed mood: ____No ____Yes

Wild mood swings: ____No ____Yes

Rapid Speech: ____No ____Yes

Extreme Anxiety: ____No ____Yes

Panic Attacks: ____No ____Yes

Phobias: ____No ____Yes

Sleep Disturbances: ____No ____Yes

Hallucinations: ____No ____Yes

Unexplained losses of time: ____No ____Yes

Unexplained memory lapses: ____No ____Yes

Alcohol/Substance abuse: ____No ____Yes

Frequent Body Complaints: ____No ____Yes

Eating Disorder: ____No ____Yes

Body Image Problems: ____No ____Yes

Repetitive Thoughts (e.g., Obsessions): ____No ____Yes

Repetitive Behaviors (e.g., Frequent checking, Hand-washing): ____No ____Yes

Homicidal Thoughts: ____No ____Yes

Suicide Attempt: ____No ____Yes

OCCUPATIONAL INFORMATION:

Are you currently employed? ____No ____Yes

If yes, who is your current employer/position? _____

If yes, are satisfied at your current position? ____No ____Yes

Please list any work-related stressors, if any:

_____

_____

_____

RELIGIOUS/SPIRITUAL INFORMATION:

Do you consider yourself to be religious? ____No ____Yes

If yes, what is your faith? _____

If no, do you consider yourself to be spiritual? ____No ____Yes

FAMILY HISTORY:

Who raised you? _____

If there were changes, please list and indicate the age you were when these changes occurred:

_____
_____

# of Siblings: _____ # of Brothers: ____ # of Sisters: ____

Which members of your family are you close to?

_____

Are there any family members who are a problem for you?

_____

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (circle any that apply and list family member , e.g., Father, Mother, Aunt, Uncle, Sibling, etc.):

Depression: ____No ____Yes _____

Bipolar Disorder: ___No ____Yes _____

Anxiety Disorders: ___No ____Yes _____

Panic Attacks: ___No ____Yes _____

Schizophrenia: ___No ____Yes _____

Alcohol/Substance Abuse: ____No ___Yes _____

Eating Disorders: ___No ____Yes _____

Learning Disabilities: ___No ____Yes _____

Trauma History: ___No ____Yes _____

Suicide Attempts: ___No ____Yes _____

Please indicate other people in your life that provide support for you:

_____
_____

OTHER INFORMATION:

What do you consider to be your strengths?

What do you like most about yourself?

What are effective coping strategies that you've learned?

What are your goals for therapy?