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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 fill out this form and bring it to your first session or allow yourself thirty minutes prior to your appointment to complete the form in the office.

Name: ____
(Last) (First) (Middle Initial)

Local Address:
____
(Street and Number)
____
(City) (State) (Zip)

Home Phone: ( ) _________________ May we leave a message? ☐ Yes ☐ No
Cell/Msg. Phone: ( ) _______________ May we leave a message? ☐ Yes ☐ No
Birth Date: ______ /______ /______ Age: _________ Gender: ☐ Male ☐ Female
Marital Status: ☐ Never Married ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed
Number of Children: _____ _____ Girl(s) ____Boy(s)
E-mail: __________________________________ May we email you? ☐ Yes ☐ No
*Please be aware that email might not be confidential.
Emergency Contact Name/Relationship
____ Phone:( )_____________ *Will only contact w/permission or meet legal criteria to break confidentiality
Referred by:
____
Are you currently receiving psychiatric services, professional counseling or psychotherapy elsewhere? ☐ Yes ☐ No
Have you had previous counseling or psychiatric care? ☐ No If Yes, previous therapist's name: ___________________________________ Any former psychiatric hospitalizations Y or N? If so, when? ____

Are you currently taking prescribed psychiatric medication (antidepressants or others)?
☐ Yes ☐ No If yes, please list:
____
____
If not, have you been previously prescribed <u>any</u> medication? ☐ Yes ☐ No
If yes, please list:
____
____

HEALTH AND SOCIAL INFORMATION

1. How is your physical health at present? (Please circle)
   Poor Unsatisfactory Satisfactory Good Very good

2. Please list any persistent physical symptoms or health concerns/chronic illnesses (e.g. chronic pain, headaches, hypertension, diabetes, surgeries, thyroid, etc.)

____

____

____

3. Are you taking any medication for any current or chronic medical conditions?

____

____

4. Are you having any problems with your sleep habits? ☐ No ☐ Yes
If yes, check where applicable: ☐ Sleeping too little ☐ Sleeping too much ☐ Poor quality sleep ☐ Disturbing dreams ☐ Other ___________________________

5. How many times per week do you exercise? _______ How long? ____________

6. Are you having any difficulty with appetite or eating habits? ☐ No ☐ Yes
If yes, check where applicable: ☐ Eating less ☐ Eating more ☐ Binging ☐ Restricting
Have you experienced significant weight change in the last 2 months?
☐ No ☐ Yes

7. Do you regularly use alcohol? ☐ No ☐ Yes
How often do you have 4 or more drinks in a 24-hour period? __________

8. How often do you engage in recreational drug use including cannabis?
☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely ☐ Never

9. How old were you when you had your first alcoholic beverage? ___________ How old were you when you first used your first substance? ____________________ What was it?____

10. Have you had suicidal thoughts recently? ☐ Frequently ☐ Sometimes ☐ Rarely ☐ Never
Have you had them in the past? ☐ Frequently ☐ Sometimes ☐ Rarely ☐ Never

11. Are you currently in a romantic relationship? ☐ No ☐ Yes
If yes, how long have you been in this relationship? _______________________
On a scale of 1-10, how would you rate the quality of your current relationship? ______

12. In the last year, have you experienced any significant life changes or stressors (loss, job change, move, deployment, etc):

____

____

13. How would you describe your experience growing up?

____

____

14. What is the last grade you completed? ___________________ and your educational experience?____
Any special education, IEP, or 504's?____

15. Family history (parents, siblings. etc) and current relationship with family members

____

____

16. Legal History (DUI, arrests, incarceration, litigation, etc)

____

____

Have you ever experienced any of the following?

Extreme depressed mood: ☐ No ☐ Yes
Extreme Mood Swings: ☐ No ☐ Yes
Rapid Speech: ☐ No ☐ Yes
Extreme Anxiety: ☐ No ☐ Yes
Panic Attacks: ☐ No ☐ Yes
Phobias: ☐ No ☐ Yes
Sleep Disturbances: ☐ No ☐ Yes
Hallucinations (tactile, visual):☐ 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
Homicidal Thoughts: ☐ No ☐ Yes
Suicide Attempt: ☐ No ☐ Yes
Repetitive Behaviors (e.g., Frequent Checking, Hand-Washing): ☐ No ☐ Yes
Repetitive Thoughts (e.g., Obsessions): ☐ No ☐ Yes
Hearing voices: ☐ No ☐ Yes
Fatigue ☐ No ☐ Yes

OCCUPATIONAL INFORMATION:

Are you currently employed? ☐ No ☐ Yes If yes, who is your current employer/position? ____

If yes, are you happy at your current position? __________________________

Please list any work-related stressors, if any: ___________________________

____

____

Previous career/jobs ____

MILITARY EXPERIENCE:

Did you or any immediate family member serve in the military? If so, who? _________________________ What branch? ___________________________________

What was your/their job in the military? ____

Deployments?____

Military Status____

RELIGIOUS/SPIRITUAL INFORMATION:

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

*Leave this question blank if you would rather not answer.

If yes, what is your faith? ____

If no, do you consider yourself to be spiritual? ☐ No ☐ Yes

Current support system:

____

____

Hobbies/Interests:

____

____

FAMILY MENTAL HEALTH HISTORY:
Have you or anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (Circle any that applies and list family member, e.g., Self, Sibling, Parent, Uncle, etc.):

Difficulty: **Family Member:**

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 (Domestic Violence, Sexual/Physical/Emotional abuse, Assault, PTSD):
☐ No ☐ Yes
____

Suicide Attempts: ☐ No ☐ Yes
____

OTHER INFORMATION:
What prompted you choose to seek out therapy? (Concerns and how long they have been going on?

____
____
____
____

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?

____

____

____

____

______________________________________ Date ________________

Signature/Relationship