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 print 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)

Name of parent/guardian (if you are a minor):
_____
(Last) (First) (Middle Initial)

Birth Date: _____ /_____ /_____ Age: _____ Gender: □ Male □ Female

Marital Status:
□ Never Married □ Partnered □ Married □ Separated □ Divorced □ Widowed

Number of Children: _____

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

Home Phone: ( ) _____ May we leave a message? □ Yes □ No

Cell/Other Phone: ( ) _____ May we leave a message? □ Yes □ No

E-mail: _____ May we email you? □ Yes □ No
*Please be aware that email might not be confidential.

Referred by: _____

Are you currently receiving psychiatric services, professional counseling or psychotherapy elsewhere? □ Yes □ No

Have you had previous psychotherapy? □No □Yes, at Previous therapist's name
_____

Are you currently taking prescribed psychiatric medication (antidepressants or others)?_____
_____
_____

If no, have you been previously prescribed psychiatric 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 (e.g. chronic pain, headaches, hypertension, diabetes, etc:

---

3. 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 _____

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

Approximately how long each time? _____

5. 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

6. Do you regularly use alcohol? No Yes In a typical month, how often do you have 4 or more drinks in a 24-hour period? _____

7. How often do you engage in recreational drug use?

Daily Weekly Monthly Rarely Never

8. Have you had suicidal thoughts recently? Frequently Sometimes Rarely Never

Have you had them in the past? Frequently Sometimes Rarely Never

9. 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? _____

---

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

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 you happy at your current position? _____

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 MENTAL HEALTH HISTORY:
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., 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: □ No □ Yes _____
Suicide Attempts: □ No □ Yes _____

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?
_____
_____
_____
_____