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):

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

Birthdate:______/______/______ Age:______ Gender: ¨ Male ¨ Female

Marital Status:
¨ Never married ¨ Partnered ¨ Married ¨ Separated ¨ Divorced ¨ Widowed

Number of Children/Ages:____

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 e-mail you? ¨ Yes ¨ No
*Please be aware that e-mail 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)?

¨ No ¨ Yes If Yes, please list:_____________________________________

If No, have you been previously prescribed psychiatric medication?

¨ No ¨ Yes If Yes, please list:_____________________________________

HEALTH & SOCIAL INFORMATION

1. How is your physical health at present?
   ¨ 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

4. If yes, check where applicable:

   ¨ Sleeping too little ¨ Sleeping too much ¨ Poor quality sleep ¨ Disturbing dreams
   ¨ Other

5. Are you having difficulty with appetite or eating habits? ¨ No ¨ Yes

   If yes, check where applicable: ¨ Eating Less ¨ Eating more ¨ Binging
   ¨ Restricting

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

   Have you had suicidal thoughts recently? ¨ Frequently ¨ Sometimes ¨ Rarely
   ¨ Never

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

9. Are you currently in a romantic relationship? ¨ No ¨ Yes

   Partner/Spouse Name:____

   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:____

If yes, are you happy at your current position:____________________________________

Please list any work-related stressors:____

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? (check 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 have learned?______________

____

____

What are your goals for therapy?______________________

____

____

Emergency Contact (Name/Phone Number):______________________