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)

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):_____