

Client Intake Form

Please provide the following information below needed for our records. All information will be held confidential in your client file. If there are questions that you do not wish to answer at this time, feel free to leave them blank. Please bring the completed form with you to your first session or email a copy prior to your appointment.

Name: _____
(Last) (First) (Middle initial)

Age: _____ Birthdate: _____ Gender: ___ M ___ F

Name of parent or guardian (if a minor):

(Last) (First) (Middle initial)

Age: _____ Birthdate: _____ Gender: ___ M ___ F

Marital Status: ___ Never Married ___ Married ___ Divorced ___ Separated
___ Widowed ___ Domestic Partnership

Please list any children and ages: _____

Home Address: _____
(Street Number)

(City) (State) (Zip Code)

Home Phone: _____
_____ yes ___ no
(okay to leave a message)

Cell/Other Phone: _____
_____ yes ___ no
(okay to leave a message)

Email: _____
_____ yes ___ no
please note that email is not always considered confidential (okay to email a message)

How did you find out about us: _____

Referred by (if any): _____

Emergency Contact Information:

(Name) (Relation) (Phone #)

Have you previously received any type of mental health services, such as counseling or psychiatric services:
___ yes ___ no

If yes: _____
(Name) (Phone)

Health and Medical

Please list current and past prescription psychiatric medication that you are taking or have taken, including dose and frequency:

How would you describe your current physical health (please circle one):

Poor Unsatisfactory Satisfactory Good Excellent

Please list any current medical conditions:

Are you having any trouble with your sleeping or eating patterns (if so, please describe):

Please check from the following list any items that you have experienced recently:

- Loss of interest in previously enjoyed activities
- Overwhelming sadness
- Crying often
- Feeling hopeless
- Overwhelming anxiety, panic, or worry
- Frequent physical complaints (headaches, etc)
- Significant change in weight
- Trouble falling asleep or staying asleep at night
- Racing or disorganized thought patterns
- Thoughts of suicide
- Irritability or anger
- Mood shifts
- Self Mutilation
- Overindulgence in alcohol, recreational drugs, or sexual activity

Family History

Please list any medical (both physical and mental health) conditions that exist within your family, as well as the family member with the condition:

Is there a history of drug/alcohol abuse and addiction in your family? If so, please describe:

Is there any history of suicide in your family? If so, please list: _____

Do you have any siblings? If so, please list with ages:

Who do you turn to for support in your family?

Occupational and Social

Are you currently employed? ___ yes ___ no

if yes, what is your current occupation: _____

Do you enjoy your current profession? ___ yes ___ no

if no what would you change: _____

Please list any current legal troubles at this time, if any:

What kind of activities or coping strategies do you use when you are stressed or overwhelmed?

What do you view to be your strengths as a person?

Briefly describe what has brought you to therapy at this time and what goals you would like to accomplish during therapy.

I have received and understand the office policies, informed consent, confidentiality, no secrets policy, and HIPAA regulations in a verbal and written format:

X _____ date _____

