CLIENT INTAKE FORM

Please answer the following questions to the best of your abilities. This information is held to the same standards of confidentiality as our therapy sessions. This questionnaire will take approximately 30 minutes to complete.

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

Name of parent or guardian (if minor):

_____
(Last) (First) (Middle initial)

Birth date: _____/_____/_____ Age: _____

Gender: ____ Male ____Female ____ Other: _____

Marital status: ___ Single ___ Partnered ___ Married ___ Separated ___ Divorced ___ Widowed

Number of children: _____ Ages: _____

Home address: _____

_____

Home phone: _____ May we leave a message? Yes No

Cell/other: _____ May we leave a message? Yes No

Email: _____ May we email you?* Yes No

**NOTE: Emails may not be confidential.*

Referred by: _____

Are you currently receiving psychological services, professional counseling, psychiatric services, or any other mental health services? Yes No

Reason for change:_____

Have you had any mental health services in the past? Yes No

Reason for change: _____

Are you currently taking any psychiatric prescription medication? Yes No

If yes, please list:_____

Have you been prescribed psychiatric prescription medication in the past? Yes No

If yes, please list:_____

General Health and Mental Health Information

How would you describe your physical health at the present time?
____Poor ____Unsatisfactory ____Satisfactory ____ Good ____ Very good

Please list any persistent physical symptoms or health concerns (e.g., chronic pain, headaches, hypertension, diabetes, thyroid dysfunction, etc.):

_____

_____

_____

Are you on any medication for physical/medical issues? Yes No

If yes, please list:_____

Are you having any problems with your quality of sleep? Yes No

If yes, check those that apply:

____ Sleep too much ____ Sleep too little ____ Poor quality ____ Disturbing dreams

____ Other:_____

How many times per week do you exercise? _____ days _____ minutes/hours

Are there any changes or difficulties with your eating habits? Yes No

If yes, check those that apply:

____ Eating less ____ Eating more ____ Bingeing ____ Restricting ____ Other: _____

Have you experienced a weight change in the last two months? Yes No

Do you consume alcohol regularly? Yes No

In one month, how many times do you have four or more drinks in a 24-hour period? _____

How often do you engage in recreational drug use?
___ Daily ___ Weekly ___ Monthly ___ Rarely ___ Never

Have you felt depressed recently? Yes No

If yes, for how long?_____

Have you had any suicidal thoughts recently? Yes No

If yes, how often? ___Frequently ___ Sometimes ___ Rarely

Have you ever had suicidal thoughts in the past? Yes No

If yes, how long ago?_____

How often did you have these thoughts? ___Frequently ___ Sometimes ___ Rarely

Are you currently in a romantic relationship? Yes No

If yes, how long have you been in this relationship?_____

On a scale from 1 to 10 (10 being great), how would you rate the quality of your relationship? _____

In the last year, have you experienced any major life changes (employment, relocation, relationship, illness, loss of loved one, etc.)? Describe.

_____

_____

Quick Check

Circle the issues below that apply to you:

Extreme depressed mood	Mood swings	Extreme anxiety	Panic attacks
Phobias	Sleep disturbance	Hallucinations	Memory lapse
Alcohol/substance abuse	Body complaints	Eating disorder	Repetitive thoughts
Anxiety	Time loss	Repetitive behaviors	Homicidal thoughts
Suicide attempts	Trouble planning	Difficulty with relationships	

Occupational Information

Are you currently employed? Yes No

If yes, who is your employer? _____

What is your position? _____

Are you happy in your current position? Yes No

Are you fulfilled in your current position? Yes No

Does your work make you stressed? Yes No

If yes, what are your work-related stressors? _____

Religious/Spiritual Information

Do you practice or observe a religion? Yes No

If yes, what is your faith? _____

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

Family Mental Health History

The following is to provide information about your family history. Please circle yes or no. If yes, please indicate the family member/relationship affected.

Depression	Yes	No	_____
Anxiety Disorders	Yes	No	_____
Bipolar Disorder	Yes	No	_____
Panic Attacks	Yes	No	_____
Alcohol/Substance Abuse	Yes	No	_____
Eating Disorder	Yes	No	_____
Learning Disability	Yes	No	_____
Trauma History	Yes	No	_____
Domestic Violence	Yes	No	_____
Obesity	Yes	No	_____
Obsessive Compulsive Behavior	Yes	No	_____
Schizophrenia	Yes	No	_____
Other _____			_____
Other _____			_____

Other Information

List your strengths:

_____

_____

_____

_____

List areas you would like to develop or improve:

_____

_____

_____

_____

What do you like most about yourself?

_____

_____

_____

_____

What are some ways you cope with life obstacles and stress?

_____

_____

_____

_____

What are your goals for therapy? What would you like to accomplish during your sessions?

_____

_____

_____

_____

Is there anything else you would like to share?

_____

_____

_____

_____