Client Intake Form

Please note: Information you provide here is strictly confidential. Answers to the following questions will help therapy be more effective and thorough.

Name:_____

Name of Parents/Guardians (if under 18 years):

_____

If parents are separated or divorced, what is the current custody arrangement?

_____

_____

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

Marital Status: □ Single □ Married □ Unmarried, but in a relationship
□ Domestic Partnership □ Separated □ Divorced □ Widowed

Do you have children? □ Yes □ No
If yes, please list names & ages: _____

Mental Health Information
Have you previously received any type of mental health services (psychotherapy, psychiatric treatment, inpatient, etc.)? □ Yes □ No
If yes, please list mental health services received, reasons for treatment, names of providers, and approximate dates of service: _____

_____

_____

Are you currently taking any prescription medication? □ Yes □ No

Please list: _____

Have you ever been prescribed psychiatric medication? □ Yes □ No

Please list medications & reasons for use. Provide approximate dates:

_____

Are you currently experiencing overwhelming sadness, depression or grief? □ Yes □ No
If yes, for approximately how long? _____

Are you currently experiencing anxiety, panic attacks, or have any phobias? □ Yes □ No
If yes, for approximately how long? _____

Physical Health Information

How would you rate your current physical health? (Please circle)

Poor Fair Good Very Good

How would you rate your sleeping habits? (Please circle)

Poor Fair Good Very Good

Are you currently experiencing any chronic pain? □ Yes □ No
If yes, please explain: _____

How many times per week do you generally exercise? _____

What types of exercise do you participate in? _____

Do you have difficulties with your appetite or eating patterns? □ Yes □ No
If yes, please explain: _____

_____

Do you have difficulties with body image? □ Yes □ No
If yes, please explain: _____

_____

How often do you drink alcohol? □ Daily □ Weekly □ Monthly □ Infrequently □ Never
How many drinks do you typically have at a sitting? □ 1-2 □ 3-4 □ More
When did you start? _____

Do you smoke cigarettes? □ Yes □ No If yes, when did you start? _____
Do you smoke marijuana? □ Yes □ No If yes, when did you start? _____

Do you engage in other recreational drug use? □ Yes □ No
If yes, when did you start? _____
What drugs do you use? _____
How often? □ Daily □ Weekly □ Monthly □ Infrequently □ Never

Are you or have you ever been involved with 12-Step? □ Yes □ No

Family Mental Health History

In the section below, please identify if there is a family history of any of the following. If yes, indicate the family member's relationship to you (ie: mother, uncle, sister, etc).

	Please Check	List Family Member
Alcohol/ Substance Abuse	☐ Yes ☐ No	
Anxiety	☐ Yes ☐ No	
Depression	☐ Yes ☐ No	
Suicide	☐ Yes ☐ No	
Domestic Violence	☐ Yes ☐ No	
Childhood Abuse	☐ Yes ☐ No	
Eating Disorders	☐ Yes ☐ No	
Obsessive Compulsive Disorder	☐ Yes ☐ No	
Schizophrenia	☐ Yes ☐ No	
PTSD	☐ Yes ☐ No	

Additional General Information

What significant life changes or stressful events have you experienced recently?

_____

_____

_____

Are you currently employed? ☐ Yes ☐ No

If yes, what is your current work situation?

_____

_____

Do you enjoy your work? Is there anything stressful about your work?

_____

_____

_____

Are you currently in a romantic relationship? ☐ Yes ☐ No

Do you enjoy your relationship? Is there anything stressful about your relationship?

_____

_____

_____

If you are single, do you enjoy being single? Is there anything stressful about being single? _____

_____

Do you have social support (ie: friends, family, social groups, etc)? □ Yes □ No
Do you feel socially isolated? □ Yes □ No

Please explain: _____

_____

Do you consider yourself spiritual or religious? □ Yes □ No
If yes, please describe your faith, belief, or religious affiliation: _____

_____

_____

What do you consider some of your strengths?

_____

_____

_____

What do you consider some of your weaknesses?

_____

_____

_____

What would you like to accomplish during your time in therapy?

_____

_____

_____