CLIENT INTAKE FORM

Please complete this form and bring it to your first session. The information you provide here is protected as confidential information.

PERSONAL INFORMATION

Name:

____

(Last) (First) (Middle Initial)

Address:

____

(Street Name and #) (City) (Zip code)

Home Phone: ( ) ____________________ May I leave a message? □ Yes □ No

Cell Phone: ( ) ____________________ May I leave a message? □ Yes □ No

Email: ____

*Please note: email is not considered a confidential mode of communication.

Birth Date: ______ /______ /______ Birth Place: ______________ Age: ________

Relationship Status: __________ Partner's/Spouse's Name: ______________________

Children/Ages:____

____

Siblings/Ages: ____

____

People living with you: ______________________________________

Emergency Contact: ______________________ Phone: ______________________

Currently employed? □ Yes □ No Retired? □ Yes □ No Disability? □ Yes □ No

If employed (or a student), where?/job title? ______________________________

Religious/Spiritual Affiliations/Practices: ______________________________

Primary Care Physician (PCP): ______________________ Phone: ______________

MEDICAL INFORMATION

Current physical or mental health diagnoses/conditions? □ Yes □ No

Please list: ____

Current prescription medication? □ Yes □ No

Please list: ____

Currently taking supplements? □ Yes □ No

Please list: ____

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

Poor Unsatisfactory Satisfactory Good Very good

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

Poor Unsatisfactory Satisfactory Good Very good

How would you rate your current **eating habits**? (Please circle one)

Poor Unsatisfactory Satisfactory Good Very good

Please explain any difficulties with sleeping or eating:

____

____

Do you currently exercise? □ Yes □ No

Is so, types and frequency? ____

____

Currently experiencing overwhelming sadness, grief, or depression? □ Yes □ No

Is yes, approximately how long? ____

Currently experiencing anxiety, panic attacks, or have any phobias? □ Yes □ No

Is yes, please describe: ____

____

Currently experiencing physical pain? □ Yes □ No

Is so, please explain: ____

____

Medical history (surgeries, injuries etc.): ____

____

Trauma/abuse history (sexual, emotional, physical, or spiritual):

____

____

<u>Please check if you have *ever* experienced:</u>

______Depression	______Addiction
______Self-Harm	______Isolation
______Suicidal Thoughts	______Nightmares/Flashbacks
______Suicide Attempts	______Low Energy
______Anxiety	______Anger/Rage
______Panic Attacks	______Aggressiveness
______Poor Concentration	______Food/Body Issues
______Mood Swings	______Risky Behavior
______Hallucinations	______Hyperactivity

Other: ____

Previous mental health services received: ____________________________________

____

How often do you use alcohol and/or recreational drugs?

□ Daily □ Weekly □ Monthly □ Infrequently □ Never

Amount/Substance(s): ____

Current stressors you are experiencing (please describe):

Health: ____

Legal: ____

Employment: ____

Financial: ____

Family/Relationship: ____

Other/Recent Life Changes: ____

Presenting Issues/Problems (What brought you here?): ________________________________

____

____

____

____

____

What do you hope to gain/accomplish in therapy? ____________________________________

____

____

____

____

____

FAMILY HISTORY

Please identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (e.g. father, grandmother, uncle, etc.)

	Family Member
Alcohol/Substance Abuse □ Yes □ No	____________________
Anxiety □ Yes □ No	____________________
Depression □ Yes □ No	____________________
Domestic Violence □ Yes □ No	____________________
Eating Disorders □ Yes □ No	____________________
Obsessive Compulsive Behavior □ Yes □ No	____________________
Schizophrenia □ Yes □ No	____________________
Suicide Attempts □ Yes □ No	____________________

ADDITIONAL INFORMATION

What do you consider to be some of your strengths? ______________________________________

____

____

Cultural identities that are important to you (race, ethnicity, gender identity, etc.): ____________

____

____

Hobbies, interests, or activities you enjoy: ______________________________________

____

____

Is there anything else you feel would be important for me to know?

____

____

____

____

____

I acknowledge that I have answered these questions truthfully and accurately to the best of my knowledge.

____ ________________

Client Signature Date