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**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 20 minutes prior to your appointment to complete the form in the office.**

Name: \_\_\_\_\_  
(Last) (First) (Middle Initial)

Name of parent/guardian (if you are a minor):  
\_\_\_\_\_  
(Last) (First) (Middle Initial)

Birth Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age: \_\_\_\_

Gender:  Male  Female

Marital Status: (Circle one)

Single  
Divorced  
Married

Local Address: \_\_\_\_\_  
\_\_\_\_\_

Home Phone: \_\_\_\_\_ May we leave a message?  Yes  No

Cell/Other Phone: \_\_\_\_\_ May we leave a message?  Yes  No

E-mail: \_\_\_\_\_ May we email you?  Yes  No

\*Please be aware that email 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 - Previous therapist's name \_\_\_\_\_

Are you currently taking prescribed psychiatric medication (antidepressants or others)?

Yes  No - If Yes, please list: \_\_\_\_\_

If no, have you been previously prescribed psychiatric medication?

Yes  No - If Yes, please list: \_\_\_\_\_

### HEALTH AND SOCIAL INFORMATION

1. How is your physical health at present? (circle one)

Poor            Unsatisfactory            Satisfactory            Good            Very good

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

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3. Are you having any problems with your sleep habits?  No  Yes

If yes, check where applicable:

Sleeping too little     Sleeping too much             Poor quality sleep     Disturbing dreams

Other \_\_\_\_\_

4. How many times per week do you exercise? \_\_\_\_\_

Approximately how long each time? \_\_\_\_\_

5. Are you having any difficulty with appetite or eating habits?  No  Yes

If yes, check where applicable:

Eating less             Eating more             Binging             Restricting

Have you experienced significant weight change in the last 2 months?  No  Yes

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

8. Have you had suicidal thoughts recently?  Frequently  Some@mes  Rarely  Never

Have you had them in the past?  Frequently  Some@mes  Rarely  Never

9. Are you currently in a romantic relationship?  No  Yes

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:

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**Current Emotional State:**

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/position? \_\_\_\_\_

If yes, are you happy at your current position? \_\_\_\_\_

Please list any work-related stressors, if any:

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**RELIGIOUS/SPIRITUAL INFORMATION:**

Do you consider yourself to be religious?  No  Yes

If yes, what is your faith? \_\_\_\_\_  
\_\_\_\_\_

**FAMILY MENTAL HEALTH HISTORY:**

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (circle any that apply and list family member, e.g., Sibling, Parent, Uncle, etc.):

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've learned?

\_\_\_\_\_  
\_\_\_\_\_

What are your goals for therapy?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

