



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 thirty 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:

Never Married Partnered Married Separated Divorced Widowed

Number of Children: _____

Local Address: _____
(Street and Number)

(City) (State) (Zip)

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, at 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? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

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

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 Sometimes Rarely Never

Have you had them in the past? Frequently Sometimes 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:

Have you ever experienced:

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: _____

RELIGIOUS/SPIRITUAL INFORMATION:

Do you consider yourself to be religious? No Yes

If yes, what is your faith? _____

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

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.):

Difficulty	Family Member
Depression: <input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Bipolar Disorder: <input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Anxiety Disorders: <input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Panic Attacks: <input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Schizophrenia: <input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Alcohol/Substance Abuse: <input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Eating Disorders: <input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Learning Disabilities: <input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Trauma History: <input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Suicide Attempts: <input type="checkbox"/> No <input type="checkbox"/> 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? _____
