CLIENT INTAKE FORM

Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information.

Today's Date:___________________________

Name: __________________________________
Address: ________________________________
____
____

Birth Date: ______ /______ /______ Age: ________ Gender: □ Male □ Female

Marital Status:
□ Never Married □ Domestic Partnership □ Married □ Separated □ Divorced □ Widowed

Please list your children and other pertinent information about them such as age, occupation, education, living situation, addiction. mental health issues:
____
____
____
____

Referred by (if any): ____

E-mail: ____
May we communicate with email, text or fax? □Yes □No

Home Phone:___________Cell/Other Phone:_____________
May we leave a message? □Yes □No

Emergency Contact:
Name________________________________Relation____
Phone Number:_____________________________

Presenting problem or issues: What would you like to work on?
____
____
____
____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?
☐ No ☐ Yes, previous therapist/practitioner and dates:

Mental Health Diagnosis:

Are you currently taking any prescription medication? ☐ Yes ☐ No
Please list medication, dosage and date:

Education____________________

Sexuality____________________

Have you ever been prescribed psychiatric medication? ☐ Yes ☐ No
Please list medication, dosage and date:

Have you struggled with any type of addiction and/or received any treatment for an addiction (drugs, alcohol, debting, spending, gambling, food, relationship, sex). Have you ever attended a detox, driver education, residential, intensive outpatient, 12 step meetings or counseling to address a substance abuse problem or an addiction.

☐ No

☐ Yes, previous therapist/practitioner/treatment programs:
Please list and provide dates:

List any positive and negative experiences from prior counseling:

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health? (please circle)
Poor Unsatisfactory Satisfactory Good Very good Please list any specific health problems you are currently experiencing:

____

____

2. How would you rate your current sleeping habits? (please circle)
Poor Unsatisfactory Satisfactory Good Very good
Please list any specific sleep problems you are currently experiencing:

____

____

3. How many times per week do you generally exercise? __________
What types of exercise to you participate in:

____

____

4. Please list any difficulties you experience with your appetite or eating patterns.

____

____

5. Self-Care Plan:

____

____

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

____

____

7. Are you currently experiencing anxiety, panic attacks, phobias, intrusive thoughts, flashbacks?
□ No □Yes
If yes, when did you begin experiencing this?

____

____

8. Are you currently experiencing any chronic pain?
□ No □ Yes
If yes, please describe?

____

____

9. Do you drink alcohol more than once a week?
□ No □ Yes

If yes, please describe?

____

____

____

10. How often do you engage recreational drug use?
☐ Daily ☐ Weekly ☐ Monthly ☐ Infrequently ☐ Never

____

____

11. Are you currently in a relationship, dating or single?
☐ No ☐ Yes If yes, for how long? ____________________
On a scale of 1-10, how would you rate your relationship?______________________________
Is there any history of domestic violence (physical, emotional, mental, verbal, sexual abuse)

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12. What significant life changes or stressful events have you experienced in the past two years:

____

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____

FAMILY HISTORY:

Family Background: tell me about your parents, where you grew up, sibs, schools, economic status, race, culture and religion.

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Family history of substance abuse and mental health~In the section below 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 (father, grandmother, uncle, etc.).

Alcohol/Substance Abuse

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Anxiety

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____

Depression

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____

Domestic Violence

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____

Eating Disorders

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____

ADD, **OCD**

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Schizophrenia/ Bi-polar Disorder/ Other

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____

Suicide Attempts

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History of Trauma and Post Traumatic Stress Disorder: {community violence, domestic violence, early childhood trauma, medical trauma, natural disaster, sexual abuse, physical abuse, neglect, abandonment, incarceration, war trauma, school violence, terrorism and traumatic grief.}

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ADDITIONAL INFORMATION:

Are you currently employed? ☐ No ☐ Yes If yes, what is your current employment situation:

____

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

____

____

Work History

____

____

____

Current Living Situation:

Do you consider yourself to be spiritual or religious? ☐ No ☐ Yes If yes, describe your faith or belief:

What do you consider to be some of your strengths?

What do you consider to be your growing edge, your work?