CLIENT INTAKE FORM

Please provide the following information. Leave blank any question you would rather not answer, or would prefer to discuss with your therapist. Information you provide here is held to the same standards of confidentiality as our therapy.

Name____

Age___________ **Birthdate** _____________________________________

Email____

Phone (preferred)____

Can I leave a message here? ____yes. ____ no

Address ____

____

TREATMENT HISTORY

Are you currently receiving psychiatric services, professional counseling or psychotherapy elsewhere? ( ) yes ( ) no

Name of professional____

Have you had previous psychotherapy?
( ) no
( ) yes, with (previous therapist's name)__________________________________

Are you currently taking prescribed psychiatric medication (antidepressants or others)? ( ) yes ( ) no

If yes, please list: ____

Prescribed by: ____

For how long?___________________ Do you find them effective?. (.). Yes ( ) No

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HEALTH AND SOCIAL INFORMATION

Do you currently have a primary physician? ( ) yes ( ) no

If yes, name ____

Are you currently seeing more than one medical health specialist? ( ) yes ( ) no

If yes, please list: ____

When was your last physical? ____

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

____

Are you currently on medication to manage a physical health concern? If yes, please list:
Problem _______________________Medication. _____________________________
____

Are you having any sleep problems? ( ) yes ( ) no

If yes, check where applicable:
( ) Sleeping too little ( ) Sleeping too much ( ) Poor quality sleep
( ) Disturbing dreams ( ) other ________________________________
(.) Can't fall asleep … (..) Can't stay asleep

How frequently do you exercise? ____________For about how long? ____________

Are you having any difficulty with appetite or eating habits? ( ) no ( ) yes

If yes, check where applicable: ( ) Eating less ( ) Eating more ( ) Bingeing
( ) Restricting other____

Have you experienced significant weight change in the last 2 months? ( ) no ( ) yes
If yes, (..) loss (..) gain …. How much? ______________

Do you regularly use alcohol? ( ) no ( ) yes

Typically, how often do you have 4 or more drinks in a 24 hour period? ________

How often do you engage in recreational drug use? ( ) daily ( ) weekly ( ) monthly

( ) rarely ( ) never

Do you smoke cigarettes or use other tobacco products? ( ) yes ( ) no
If you have ever smoked, how long ago did you quit?___________________

Have you had suicidal thoughts recently?
( ) frequently ( ) sometimes ( ) rarely ( ) never

Have you had them in the past?
( ) frequently ( ) sometimes ( ) rarely ( ) never

Are you currently in a romantic relationship? ( ) no ( ) yes

Sexual orientation ____

Are you . (..) married.. (..) living together. (..) divorced.. (..) separated (..) widowed?

If in a relationship, how long have you been together? _______________________

On a scale of 1-10 (10 being the highest quality), how would you rate your current relationship? ________

Please names and ages of children, if any:

___

___

___

Please list names and relationship of people who are your primary social supports:

___

___

In the last year, have you experienced any significant life changes? If yes, please explain:

___

___

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Have you ever experienced any of the following? If yes, please explain….

Extreme depressed mood	Yes / No
Dramatic mood swings	Yes / No
Rapid speech	Yes / No
Anxiety	Yes / No
Panic attacks	Yes / No
Phobias	Yes / No
Sleep disturbances	Yes / No
Hallucinations	Yes / No
Unexplained losses of time	Yes / No
Sexual or physical abuse	Yes / No
Alcohol/substance abuse	Yes / No
Frequent body complaints	Yes / No
Eating/body image disorder	Yes / No
Suicidal thoughts	Yes / No
Repetitive thoughts (e.g. obsessions)	Yes / No
Repetitive behaviors (e.g. frequent checking, hand washing	Yes / No
Homicidal/violent thoughts	Yes / No
Suicidal attempts	Yes / No If yes, when?

OCCUPATIONAL INFORMATION

Are you currently employed? ( ) no ( ) yes

If yes, who is your currently employer/position? ____________________________

____

Please list any work-related stressors, if any ___________________________________

____

____

If not employed, ___ seeking employment ____ retired ____ choose not to work ____ gave up looking

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RELIGIOUS/SPIRITUAL INFORMATION

Do you consider yourself to be religious? (   ) no (   ) yes

Do you consider yourself to be spiritual? (   ) no (   ) yes

If religious, what is your faith? ____________________________

Are you part of a spiritual or religious community?. (..). Yes.. (…).. No

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	**Yes / No**	**Family member**
Depression	Yes / No	
Bipolar disorder	Yes / No	
Anxiety disorder	Yes / No	
Panic attacks	Yes / No	
Schizophrenia	Yes / No	
Alcohol/substance abuse	Yes / No	
Eating disorders	Yes / No	
Learning disabilities	Yes / No	
Trauma history	Yes / No	
Suicide attempts	Yes / No	
Chronic illness	Yes / No	

OTHER INFORMATION

What do you consider to be your strengths? ___________________________________

____

____

Presently, what are your primary stressors?_ _________________________

____

What are the effective coping strategies that you have learned? ___________________

____

____

What are your goals for therapy?

____

____

____

____

Is there anything else that you think would be helpful for me to know?

____

____

____

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