

Client Initials: \_\_\_\_\_

# Client Intake Form

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Please provide the following information for our records. Information you provide here is held to the same standards of confidentiality as our therapy.

Please print out this form, completed and signed, and bring it to your first appointment.

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

For clients under age 18, name of parent/guardian:

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

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

Gender:  Male  Female  Transgender M to F  Transgender F to M

Marital Status:  Single  Divorced  Separated  Married  Long-term Relationship

Live with: \_\_\_\_\_

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

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

Cell/Other Phone: \_\_\_\_\_ May we leave a message?  Yes  No May we text you at this number?  Yes  No

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

\*Please be aware that text and email may not be confidential.

Emergency contact name and phone number: \_\_\_\_\_

Referred by: \_\_\_\_\_

May we contact the referral to thank them? \_\_\_\_\_

PRESENTING PROBLEMS AND CONCERNS

Describe the problem that brought you here today: \_\_\_\_\_

How long has this been a problem? \_\_\_\_\_

Please check all the behaviors and symptoms you consider problematic:

- Distractibility
- Hyperactivity
- Impulsivity
- Boredom
- Poor memory/confusion
- Seasonal mood changes
- Sadness/depression
- Loss of pleasure/interest
- Hopelessness
- Thoughts of death
- Self-harm behaviors
- Crying spells
- Loneliness
- Low self-worth
- Guilt/shame
- Fatigue
- Rapid speech
- Phobias
- Excessive exercise
- Change in appetite
- Lack of motivation
- Withdrawal from people
- Anxiety/worry
- Panic attacks
- Fear away from home
- Social discomfort
- Obsessive/intrusive thoughts
- Compulsive behavior
- Aggression/fights
- Frequent arguments
- Irritability/anger
- Homicidal thoughts
- Flashbacks
- Hearing voices
- Visual hallucinations
- Unexplained losses of time
- Suicide attempt
- Other: \_\_\_\_\_
- Suspicion/paranoia
- Racing thoughts
- Excessive energy
- Wide mood swings
- Sleep problems
- Nightmares
- Eating problems
- Gambling problems
- Computer/mobile addiction
- Problems with pornography
- Parenting problems
- Sexual problems
- Relationship problems
- Work/school problems
- Alcohol/drug use
- Recurring, disturbing memories
- Unexplained memory lapses
- Body image/body complaints

Are your problems affecting any of the following?

- Handling everyday tasks
- Self esteem
- Relationships
- Hygiene
- Work/school
- Housing
- Legal matters
- Finances
- Recreational activities
- Sexual activity
- Health

Have you noticed times when the problem isn't as bad? \_\_\_\_\_

Has anything like this happened before (when, how often)? \_\_\_\_\_

How did you try to resolve this problem the last time? \_\_\_\_\_

Who is involved or affected by this current problem/situation? \_\_\_\_\_

Yes  No Have you had ever had thoughts, made statements, or attempted to hurt yourself? If yes, please describe: \_\_\_\_\_

Yes  No Have you had ever had thoughts, made statements, or attempted to hurt someone else?  No  Yes, please describe: \_\_\_\_\_

Yes  No Have you gambled in the past 6 months? If yes, please let us know the following:

Yes  No Have you ever felt the need to bet more and more money?

Yes  No Have you lied to people important to you about how much you gambled?

Yes  No Have you recently been physically hurt or threatened by someone else? If yes, please describe: \_\_\_\_\_

Yes  No Have you been physically hurt or threatened in the past (including sexual

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abuse/trauma)? If yes, please describe (to the extent you are comfortable): \_\_\_\_\_

Yes  No Are you engaging in other behaviors you have difficulty controlling or stopping, or that others have expressed concern about (e.g. gaming, pornography, etc.)  No  Yes, please describe: \_\_\_\_\_

## HEALTH AND SOCIAL INFORMATION

**Mental Health** - Are you currently receiving psychiatric services, professional counseling or psychotherapy?  Yes  No If yes, who is your current provider? \_\_\_\_\_

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 medication, frequency, and dose: \_\_\_\_\_

If no, have you been previously prescribed psychiatric medication?  Yes  No - If Yes, please list medication, dose, and reason for prescription and for discontinuing: \_\_\_\_\_

**Physical Health** - How is your physical health at present?  Poor  Unsatisfactory  Satisfactory  Good  Very good

When was your last physical exam: \_\_\_\_\_ Name of physician: \_\_\_\_\_

Are you taking any medications:  No  Yes, please list: \_\_\_\_\_

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

Have you had any recent hospitalizations:  No  Yes, please describe: \_\_\_\_\_

**Sleep** - If you answered yes to problems with sleep, check where applicable:  Sleeping too little  Sleeping too much  Poor quality sleep  Disturbing dreams  Other \_\_\_\_\_

**Activity Level** - How many times per week do you exercise? \_\_\_\_\_ Approximately how long each time? \_\_\_\_\_ And to what intensity? \_\_\_\_\_

**Eating** - If you answered yes to problems with appetite or eating habits, check where applicable:  Eating less  Eating more  Binging  Restricting

Have you experienced significant weight change in the last 2 months?  No  Yes, please describe: \_\_\_\_\_

**Substance Use** - 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? \_\_\_\_\_

Have you experienced guilt or a desire to quit drinking, or have others indicated concern?  No  Yes, please describe: \_\_\_\_\_

Have you been charged with a DUI/DWI or similar offense? If yes, indicate date(s) and result: \_\_\_\_\_

How often do you engage in recreational drug use (prescription, non-prescription, legal, or illegal)?

Daily  Weekly  Monthly  Rarely  Never Type: \_\_\_\_\_ Last use: \_\_\_\_\_

**Relationships** - Are you currently in a romantic relationship?  No  Yes, for how long? \_\_\_\_\_

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Quality of current relationship (rate 1-10)? \_\_\_\_\_ How would you describe your sexual orientation? \_\_\_\_\_

Describe any problems in the area of relationships or sexual orientation: \_\_\_\_\_

Describe how you generally get along with other people (e.g. affectionate, follower, aggressive, shy, withdrawn, submissive, avoidant, leader, fight or argue, outgoing, etc.)

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

**Stress** - In the last year, have you experienced any significant life changes or stressors – please describe:

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

**Legal** - Have you had any recent problems with the police or other legal problems?  No  Yes, please describe:

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

#### EDUCATION / OCCUPATIONAL INFORMATION:

Are you currently employed?  No  Yes If yes:  Full-time  Part-time

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: \_\_\_\_\_

If no, do you desire to be employed? \_\_\_\_\_

Are you currently enrolled in school?  No  Yes If yes, describe: \_\_\_\_\_

Highest level of education completed: \_\_\_\_\_

#### CULTURAL/ETHNIC INFORMATION:

How do you describe your ethnicity? \_\_\_\_\_

Are you experiencing any problems due to cultural or ethnic issues? If yes, please describe:

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

Other cultural information you believe is important for me to know:

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

#### 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

How were you raised regarding spiritual things or religion? \_\_\_\_\_

Would you like to incorporate your faith into therapy sessions?  No  Yes

If yes, how would you like to incorporate your faith (e.g. prayer, scripture, etc.)

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

#### LEISURE/RECREATIONAL

Describe special areas of interest or hobbies (e.g. art, books, crafts, working out, sports, hiking, church activities, volunteering, traveling, bowling, etc.): \_\_\_\_\_

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

How often do you engage in these activities? \_\_\_\_\_

How often did you engage in them in the past? \_\_\_\_\_

**FAMILY MENTAL HEALTH HISTORY:**

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (check all 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:  No  Yes \_\_\_\_\_

**GOALS:**

What is your goal in coming to counseling / why are you seeking therapy now?

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

What would you like to get out of this appointment time? \_\_\_\_\_

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

What changes would you like to see happen? \_\_\_\_\_

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

What are some things in your current situation you would like to keep or stay the same?

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

How will you know (what will you be thinking and doing differently) that you won't need to come back anymore:

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

**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? \_\_\_\_\_

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

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Anything else you would like your counselor to know about you:

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Client Signature

Date

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If under age 18 - Parent Signature

Date