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 MtoF □ Transgender FtoM □ Non-binary (GAB □ M □ F)

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
□ 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
□ Suspicion/paranoia
□ Racing thoughts
□ Excessive energy
□ Wide mood swings
□ Sleep problems
□ Nightmares
□ Eating problems
□ Gambling problems
□ Computer/mobile addiction
□ Problems with pornography
□ Risky/illegal sexual behavior
□ Parenting problems
□ Crying spells
□ Loneliness
□ Low self-worth
□ Guilt/shame
□ Fatigue
□ Irritability/anger
□ Homicidal thoughts
□ Flashbacks
□ Hearing voices
□ Visual hallucinations
□ Sexual problems
□ Relationship problems
□ Work/school problems
□ Alcohol/drug use
□ Recurring, disturbing memories
□ Rapid speech
□ Phobias
□ Excessive exercise
□ Unexplained losses of time
□ Unexplained memory lapses
□ Suicide attempt
□ Body image/body complaints
□ Other: _____

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? _____ If yes, how did you try to resolve this problem the last time? _____How often has this problem occurred? _____

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? If 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 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, other sexual behaviors, etc.) If 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 & Sexuality- Are you currently in a romantic relationship? □ No □ Yes, for how long? _____

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? _____

_____

_____

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

_____

_____

_____

Client Signature Date

_____

Client Printed Name Date

_____

If minor - Parent Signature Date

_____

If minor - Parent Printed Name Date