Client Intake Form

Please provide the following information and answer the questions below. Information that you provide here is protected as confidential information. Please bring this completed form with you to your first appointment. Thank you.

Name: _____
(First) (Middle Initial) (Last)

Name of parent/guardian (if under 18 years):

_____

Address: _____City/State/Zip:_____

Telephone: _____ May I leave a message? □ Yes □ No

E-mail:_____Please note: Email correspondence is not considered to be a confidential medium of communication.

Birth Date: _____ /_____ /_____ Age: _____ Gender: □ Male □ Female

Marital Status:

□ Never Married	□ Married	□ Domestic Partnership
□ Separated	□ Divorced	□ Widowed

Please list any children/age(s):

_____

Reason for Today's Appointment: _____

_____

Emergency Contact/Relationship:_____
Name Phone No.

Current Occupation: _____

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

_____

Are you currently taking any prescription medication?
□ Yes
□ No
Please list: _____

Have you ever been prescribed psychiatric medication?
□ Yes
□ No
Please list and provide dates: _____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION:

1. 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 pattern:

_____

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

6. Are you currently experiencing anxiety, panic attacks, or have any phobias?
□ No
□ Yes
If yes, when did you begin experiencing this? _____

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

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

9. How often do you engage recreational drug use?
□ Daily □ Weekly □ Monthly □ Infrequently □ Never

10. Are you currently in a romantic relationship? □ No □ Yes - For how long? _____
On a scale of 1-10, how would you rate your relationship? _____

11. What significant life changes or stressful events have you experienced recently?

_____

FAMILY MENTAL HEALTH HISTORY: Please identify if there is a family history of any of the following.

Please Check	List Family Member
_____Alcohol/Substance Abuse	_____
_____Anxiety	_____
_____Depression	_____
_____Domestic Violence	_____
_____Eating Disorders	_____
_____Obsessive Compulsive Behavior	_____
_____Schizophrenia	_____
_____Suicide or Suicide Attempt	_____

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