Client Intake Form

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

Name: _____ _____ _____
First Middle Initial Last

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 form of communication.

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

Marital Status:

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

Please list any children/age(s):
_____

Emergency Contact Name: _____
Phone Number: _____
Relationship: _____

Employer & Job Title: _____

Referred By: _____

Reason for Today's Appointment/Things You Would Like to Discuss:

_____
_____
_____
_____

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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?

_□_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. How many alcoholic beverages do you drink per week? _____

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

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

10. 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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