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Client Intake Form

These questions are intended to help me gather information to better understand you and make the most of our time together. Please complete all sections that apply to you. You may spend as much time on this as feels right. All information is kept confidential.

Name: _____ Birth Date: ____/____/____ Age: _____

Date of first appointment: _____ Gender: Male Female Other _____

Referred by:

- Google Search - searched for: _____
- Psychology Today OnlineTherapy.com reflect.com Zencare Lyra ModernHealth Advekit
- Medical Provider: _____
- Friend/Family: _____
- Other: _____

Contact Info:

Address: _____ (Street and Number)
_____ (City, State, Zip)

Home Phone: _____ May I leave a message? Yes No

Cell/Other: _____ May I leave a message? Yes No

E-mail: _____ May I email you? Yes No

Would you like to be added to my mailing list to receive my updates, mental health tips, and resources? Yes No

Emergency Contact:

Name: _____
Relationship: _____ Phone number: _____

Personal Info:

Occupation: _____
Place of Employment: _____
Work number: _____ If needed, is it ok to call here? Yes No

Have you previously received any type of mental health services? No Yes
If yes, which of the following: psychotherapy medication outpatient hospitalizations inpatient hospitalization
Name of provider(s) or facility: _____

Contact info of provider(s): _____

Dates of treatment: _____

Reason for treatment: _____

Briefly, what brings you in today? _____

When did this first start? Within the last: 30 days 6-12 months 2 years During adolescence During childhood

What areas of your life have been affected because of this? _____

Are you currently experiencing overwhelming sadness, grief or depression? No Yes

If yes, for approximately how long? _____

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

Please describe any major losses or traumas you have experienced: _____

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

What would you like to accomplish out of your time in therapy? _____

Family History:

Where were you born? _____ Where did you grow up? _____

Please list your parents and siblings:

Name _____ Age _____ Relationship _____

Name _____ Age _____ Relationship _____

Name _____ Age _____ Relationship _____

Name _____ Age _____ Relationship _____

Name _____ Age _____ Relationship _____

Where do they now live? _____

If deceased, include age and cause of death: _____

Who did you live with, growing up? _____

Mother's occupation: _____ Father's occupation: _____

In the section below identify if there is a family history of any of the following:

If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

Condition	Please circle	List Family Member
Alcohol/Substance Abuse	yes/no	_____
Anxiety	yes/no	_____
Depression	yes/no	_____
Domestic Violence	yes/no	_____
Sexual Abuse	yes/no	_____
Eating Disorders	yes/no	_____
Obesity	yes/no	_____
Obsessive Compulsive Behavior	yes/no	_____
Schizophrenia	yes/no	_____
Suicide Attempts	yes/no	_____
Other mental health condition?	yes/no : which was---	_____

Marital Status: Never Married Domestic Partner Married For how long? _____

Separated Divorced Widowed If widowed, please give partners name, and year deceased: _____

Please give partner's name: _____

On a scale of 1-10 (best), how would you rate your relationship? _____

Are you currently in a romantic relationship? No Yes If yes, for how long? _____

On a scale of 1-10, how would you rate your relationship? _____

Please list any children, their names, and ages:

Name _____ Age _____ Name _____ Age _____

Name _____ Age _____ Name _____ Age _____

Name _____ Age _____ Name _____ Age _____

Name of other parent _____ If deceased, age and cause of death _____

Physical Health

Please list any medications, herbs, or supplements. Be sure to include the condition, as some medications are prescribed for off-label use. If you have a complicated medical profile, please supply supporting documentation to be able to facilitate a comprehensive understanding of your health.

Medication/Supplement	Dosage	Condition	Began/Stopped
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Prescribing provider and contact information:

Name: _____ Facility: _____

Specialty: _____ Phone, email, or Fax: _____

How would you rate your current physical health? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing: _____

How would you rate your current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

If you are having problems, in which phase of sleep? (please circle)

Falling asleep staying asleep awakening early sleep apnea

Please list any other specific sleep problems you are currently experiencing: _____

How many times per week do you generally exercise? _____

What types of exercise do you participate in? _____

Please list any difficulties you experience with your appetite or eating patterns: _____

Any change in weight over the past year? No Yes: _____

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

Please describe *current* use of alcohol, marijuana, and/or other recreational drugs, including frequency & amount: _____

Please describe *previous* use of alcohol, marijuana, and/or other recreational drugs, including frequency & amount: _____

***Do you agree to not use alcohol, marijuana, and other recreational drugs for 24 hours before a session?** No Yes

If no, please share why _____

Strengths & Additional Info

What do you enjoy about your work (full-time homemaker included)? _____

If retired, what did you enjoy about your work? _____

What do you find particularly stressful about your current or previous work? _____

What do you enjoy doing in your free time? _____

What do you do to relax? _____

What brings you joy? _____

Do you consider yourself to be spiritual or religious? No Yes If yes, describe your faith or belief: _____

What do you consider to be some of your strengths? _____

What do you consider to be some of your weaknesses? _____
