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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: ______________

Current Gender Identity: ◻ Male ◻ Female ◻ Non-binary

◻ Transmasculine ◻ Transfeminine ◻ Other _________

Sex Assigned at Birth: ◻ Male ◻ Female

Referred by:

◻ Google Search - searched for: ______________________

◻ Psychology Today ◻ TherapyDen ◻ reflect.com ◻ Zencare ◻ ModernHealth

◻ 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 emailing list to receive updates, mental health tips, and resources? ◻ Yes ◻ No

Emergency Contact:

Name: ____

Relationship: __________________________________ Phone number: _________________________

Do you give permission to contact this person in case of an emergency? □ Yes □ No

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: ____

Are your parents □ Married □ Divorced If divorced, when? ____________________________________

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—	____________________

Sexual Orientation:

How do you identify? □ Heterosexual □ Lesbian □ Gay □ Queer □ Bisexual □ Trans □ Asexual

□ Pansexual □ Other ___________

Relationship Status:

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

Relationship structure/Agreements: □ Monogamous □ Non-monogamous □ Polyamorous □ Other ______

Comments: ____

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

Marital Status: □ Never Married □ Domestic Partner □ Married For how long? ______

□ Separated □ Divorced □ Widowed If widowed, please give partner's name, and year deceased: __
____

What is/are your partner's name(s)? __________________________

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

Prescribing provider and contact information:

Name: ________________________________ Facility: ___________________________________

Specialty/License: ______________________ 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 12 hours before a session?** □ No □ Yes If no, please share why ____
____
______

Strengths & Additional Info

What do you enjoy about your work (inside or outside the home)? ____________________________
____
____

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 or areas you would like to grow? _________
____
____