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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: _____ Pronouns: _____ Birth Date: ____/____/_____ Age: _____
Date of first appointment: _____

Current Gender Identity: _____ Cultural Background/Identity: _____

Referred by:
▫ Google Search - searched for: _____
▫ Psychology Today ▫ OnlineTherapy.com ▫ EmbodyLab ▫ Zencare ▫ TherapyDen ▫ EB/Marin CAMFT
▫ Medical/Health Practitioner: _____
▫ 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: _____
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? _____
_____
_____

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

How has this impacted your life? _____
_____

Are you currently experiencing overwhelming sadness, grief or depression? ▫ No ▫ Yes - for how long? _____
Are you currently experiencing anxiety, panic attacks or have any phobias? ▫ No ▫ Yes - when did it start? _____

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--- _____

**Relationship Status:**

Current sexual orientation/how do you identify? _____
Are you currently in a romantic relationship? ▫ No ▫ Yes If yes, for how long? _____
Relationship structure: ▫ Monogomous ▫ Non-monogomous ▫ Polyamorous ▫ Other: _____
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 partners name, and year deceased: _____
What's your current partner's(s) name? _____

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 & License: _____ Facility: _____
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: _____
_____

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

How do you exercise and how often? _____

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 and 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 current or previous work (full-time homemaker included)? _____
_____

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

How do you 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 growth edges? _____
_____