CLIENT INTAKE FORM

Please provide the following information for our records. Leave blank any question you would rather not answer. Information you provide here is held to the same standards of confidentiality as our therapy. Please print out this form and bring it to your first session or allow yourself thirty minutes prior to your appointment to complete the form in the office.

Readmit: _____ Yes _____ No Date: _____

Driver License #: _____

Social Security #:_____ Race: _____

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

Name of parent/guardian (if you are a minor):

_____
(Last) (First) (Middle Initial)

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

Marital Status:
□ Never Married □ Partnered □ Married □ Separated □ Divorced □ Widowed

Number of Children: _____

Local Address: _____
(Street and Number)

_____
(City) (State) (Zip)

Home Phone: ( ) _____ May we leave a message? □ Yes □ No

Cell/Other Phone: ( ) _____ May we leave a message? □ Yes □ No

E-mail: _____ May we email you? □ Yes □ No
*Please be aware that email might not be confidential.

Veteran: _____ _____ No

Are you currently receiving psychiatric services, professional counseling or psychotherapy elsewhere? □ Yes □ No

Have you had previous psychotherapy?
□No □Yes, at previous therapist's name _____

Are you currently taking prescribed psychiatric medication (antidepressants or others)?

□Yes □No If Yes, please list: _____

If no, have you been previously prescribed psychiatric medication?

□Yes □No If Yes, please list: _____

HEALTH AND SOCIAL INFORMATION

Allergies: _____

1. How is your physical health at present? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

2. Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.):

_____

3. Are you having any problems with your sleep habits? □ No □ Yes

If yes, check where applicable:
□ Sleeping too little □ Sleeping too much □ Poor quality sleep □ Disturbing dreams

□ Other _____

4. How many times per week do you exercise? _____

Approximately how long each time? _____

5. Are you having any difficulty with appetite or eating habits? □ No □ Yes

If yes, check where applicable: □ Eating less □ Eating more □ Binging □ Restricting

Have you experienced significant weight change in the last 2 months? □ No □ Yes

6. Do you regularly use alcohol? □ No □ Yes

In a typical month, how often do you have 4 or more drinks in a 24-hour period? _____

7. How often do you engage in recreational drug use?

□ Daily □ Weekly □ Monthly □ Rarely □ Never

8. Have you had suicidal thoughts recently? □ Frequently □ Sometimes □ Rarely □ Never

Have you had them in the past? □ Frequently □ Sometimes □ Rarely □ Never

9. Are you currently in a romantic relationship? □ No □ Yes

If yes, how long have you been in this relationship? _____

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

10. In the last thirty days to one year, have you experienced any significant life changes or stressors:

_____

Have you ever experienced:

Extreme depressed mood: □ No □ Yes

Wild Mood Swings: □ No □ Yes

Rapid Speech: □ No □ Yes

Extreme Anxiety: □ No □ Yes

Panic Attacks: □ No □ Yes

Phobias: □ No □ Yes

Sleep Disturbances: □ No □ Yes

Hallucinations: □ No □ Yes

Unexplained losses of time: □ No □ Yes

Unexplained memory lapses: □ No □ Yes

Alcohol/Substance Abuse: □ No □ Yes

Frequent Body Complaints: □ No □ Yes

Eating Disorder: □ No □ Yes

Body Image Problems: □ No □ Yes

Repetitive Thoughts (e.g., Obsessions): □ No □ Yes

Repetitive Behaviors (e.g., Frequent Checking, Hand-Washing): □ No □ Yes

Homicidal Thoughts: □ No □ Yes

Suicidal Thoughts □ No □ Yes

Suicide Attempt: □ No □ Yes

Family History of Suicide □ No □ Yes

FAMILY MENTAL HEALTH HISTORY:

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (Circle any that apply and list family member, e.g., Sibling, Parent, Uncle, etc.):

Difficulty	**Family Member**
Depression: □ No □ Yes	_____
Bipolar Disorder: □ No □ Yes	_____
Anxiety Disorders: □ No □ Yes	_____
Panic Attacks: □ No □ Yes	_____
Schizophrenia: □ No □ Yes	_____
Alcohol/Substance Abuse: □ No □ Yes	_____
Eating Disorders: □ No □ Yes	_____
Learning Disabilities: □ No □ Yes	_____
Trauma History: □ No □ Yes	_____
Suicide Attempts: □ No □ Yes	_____

OCCUPATIONAL INFORMATION:

Are you currently employed? □ No □ Yes

If yes, who is your current employer/position? _____

If yes, are you happy at your current position? _____

Please list any work-related stressors, if any: _____

RELIGIOUS/SPIRITUAL INFORMATION:

Do you consider yourself to be religious? □ No □ Yes

If yes, what is your faith? _____

If no, do you consider yourself to be spiritual? □ No □ Yes

OTHER INFORMATION:

What do you consider to be your strengths? _____

_____

_____

_____

What do you like most about yourself? _____

_____

_____

What are effective coping strategies that you've learned? _____

_____

_____

What are your goals for therapy? _____

_____

_____

Emergency Information
In case of emergency, Contact:

Name (1) _____ Relationship _____

Address _____

City _____ State_____ Zip _____

Home Phone_____ Cell Phone _____ Work Phone _____

E-mail:_____

May we leave a phone voice message □ No □ Yes at work □ No □ Yes

May we communicate by email □ No □ Yes

Name (2) _____ Relationship _____

Address _____

City _____ State_____ Zip _____

Home Phone_____ Cell Phone _____ Work Phone _____

E-mail:_____

May we leave a phone voice message □ No □ Yes at work □ No □ Yes

May we communicate by email □ No □ Yes

Physician's Name _____ Phone _____

Address _____

City _____ State_____ Zip _____

Psychiatrist's Name _____ Phone _____

Address _____

City _____ State_____ Zip _____

Counselor's Name _____ Phone _____

Address _____

City _____ State_____ Zip _____

PO's Name _____ Phone _____

Address _____

City _____ State_____ Zip _____

Insurance Information

Primary Insurance _____Secondary Insurance _____

Contract ID # _____ Contract ID # _____

Group ACCT # _____ Group ACCT # _____

Subscriber _____ Subscriber _____

Subscriber Date of Birth _____ Subcriber Date of Birth _____

Client's Relationship to Subscriber Client's Relationship to Subscriber

□ Self □ Spouse □ Child □ Other □ Self □ Spouse □ Child □ Other

Referred Source:

How did you hear of this office (or from whom)? _____

Address _____ City_____ State _____

Relationship to referral source: _____ Phone _____