



CLIENT INTAKE FORM

Name _____ Today's Date __/__/__
Street Address _____ Date of Birth __/__/__
City, State, Zip _____ Current Age _____
Home phone _____ Work phone _____ Cell phone _____
E-mail address _____ Occupation _____
Referred by _____

In case of emergency, you have my permission to notify:

Name _____ Phone _____ Relationship to you: _____

Background

Marital/Relationship status _____ (partner/spouse's first name _____)

Children's names & ages (if any) _____

Have you received psychotherapy or counseling before? (Yes / No). If so, please indicate dates of treatment and reason for starting and stopping.

Please describe who was in your household as a child (including birth order and birth year for siblings).

Health History

Current health concerns _____

Psychiatrist (if any) _____ Phone _____

Current medications (include dose & frequency) _____

Prior medication use & dates _____

Any psychiatric hospitalizations? If so, when? _____

Have you ever felt suicidal? _____ When was the last time? _____

Non-prescription drugs/alcohol/smoking/caffeine (include amount & frequency) _____

What do you do for exercise, and how often? _____

Current issues

Please indicate any areas of your life which are especially challenging at this time (mark with a "C"), and any which feel particularly satisfying or nourishing at this time (mark with an "S").

career path	health & body	family relationships	finances
intimacy/sexuality	parenting	(finding) life partner	housing
spiritual life	work relationships	life balance	social life/ friendships
transitions	environmental/political concerns	other _____	

Please indicate which of the following, if any, are present in your life by circling the appropriate number after each item.

	<i>never</i>	<i>occasional</i>	<i>often</i>	<i>always</i>
easily stressed	1	2	3	4
anxiety	1	2	3	4
panic attacks	1	2	3	4
cry easily / overly emotional	1	2	3	4
irritability	1	2	3	4
obsessive thinking	1	2	3	4
mood swings	1	2	3	4
anger and explosivity	1	2	3	4
feeling powerless when facing conflict	1	2	3	4
thoughts of revenge	1	2	3	4
nightmares	1	2	3	4
difficulty sleeping	1	2	3	4
difficulty relating to groups	1	2	3	4
difficulty relating to intimate partner	1	2	3	4
gastrointestinal complaints	1	2	3	4
headaches and migraines	1	2	3	4
back or neck pain	1	2	3	4
widespread muscle tension and/or myalgia	1	2	3	4
feeling separate from your body	1	2	3	4
feeling your surroundings are unreal	1	2	3	4
intolerance to light and/or sound	1	2	3	4
sexual problems or troubling fantasies	1	2	3	4
eating disorders or food-related issues	1	2	3	4
alcohol or drug dependence	1	2	3	4
workaholism	1	2	3	4
self-injury	1	2	3	4
low energy and fatigue	1	2	3	4
depression	1	2	3	4
feelings of loneliness	1	2	3	4
low self-esteem	1	2	3	4
shame	1	2	3	4
other: _____	1	2	3	4

Trauma History (if any)

Did you have traumatic experiences in your childhood and adolescence (e.g. emotional neglect, abuse by a caregiver, car accident, discrimination, divorce of parents, loss of loved ones, school or sibling bullying)?

Yes No I don't know

Brief description (optional):

Any traumatic experiences or significant losses in your adult life? Yes No I don't know

Brief description (optional):

How have these impacted your life?

Supports

What are your primary coping strategies? How well do these work for you?

Who are your primary social supports?

Goals for Therapy

Please describe your current symptoms and reasons for coming to therapy.

If this therapy is successful, what will be different in your life?

Is there anything else that would you like me to know about you at this point?

Signature _____ Date _____