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CLIENT INTAKE

Information provided on this form is protected as confidential information.

PERSONAL INFORMATION

Name:____ Date: _______________________

DOB: ______________________ Age: __________ Ethnicity: ___________________________

Gender: ☐ Female ☐ Male ☐ Transgender ☐ Intersex ☐ Other ☐ Prefer not to say

Preferred Pronouns (ex: he/his, her/hers): ____________________________________

Parent/Legal Guardian (if under 18): ____

Address: ____

Cell Phone: ______________________________________ May we leave a message? ☐ YES ☐ NO

Home/Work/Other Phone: _________________________ May we leave a message? ☐ YES ☐ NO

Email: ____ May we leave a message? ☐ YES ☐ NO

**Please note: Email correspondence is not considered to be a confidential medium of communication.*

Relationship Status: ☐ Never Married ☐ Domestic Partnership ☐ Married ☐ Separated

☐ Divorced ☐ Widowed ☐ Other: ____________________________

Please list any prescribed medications or vitamins, herbs, supplements you are <u>currently</u> taking:

____

____

Have you previously received any type of mental health services/counseling?

Individual: ☐ YES ☐ NO ☐ Currently Receiving Name of Clinician: ____________________

Couples: ☐ YES ☐ NO ☐ Currently Receiving Name of Clinician: ____________________

Family: ☐ YES ☐ NO ☐ Currently Receiving Name of Clinician: ____________________

Have you previously received a mental health diagnosis? ☐ YES ☐ NO

If yes, please describe and list when diagnosis was received: ___________________________________

Referred By (if any): ____

CHILDREN INFORMATION

Name:____ Age: _____________

Name:____ Age: _____________

Name:____ Age: _____________

Name:____ Age: _____________

GENERAL HEALTH INFORMATION

How would you rate your current ***physical*** health?

□ Poor □ Unsatisfactory □ Satisfactory □ Good □ Very good

Please list any specific problems you are currently experiencing: ___________________________________

How would you rate your current ***mental*** health?

□ Poor □ Unsatisfactory □ Satisfactory □ Good □ Very good

Please list any specific problems you are currently experiencing: ___________________________________

How would you rate your current ***sexual*** health?

□ Poor □ Unsatisfactory □ Satisfactory □ Good □ Very good

Please list any specific problems you are currently experiencing: ___________________________________

How would you rate your current ***spiritual*** health?

□ Poor □ Unsatisfactory □ Satisfactory □ Good □ Very good

Please list any specific problems you are currently experiencing: ___________________________________

How would you rate your current ***financial*** health?

□ Poor □ Unsatisfactory □ Satisfactory □ Good □ Very good

Please list any specific problems you are currently experiencing: ___________________________________

How would you rate your current sleeping habits?

□ Poor □ Unsatisfactory □ Satisfactory □ Good □ Very good

Please list any specific 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 problems: ____________________

Are you currently experiencing overwhelming sadness, grief, or depression? □ YES □ NO

If yes, please describe and when did you begin experiencing? ___________________________________

Are you currently experiencing anxiety, panics attacks or have any phobias? □ YES □ NO

If yes, please describe and when did you begin experiencing? ___________________________________

Are you currently experiencing any chronic pain? □ YES □ NO

If yes, please describe: ____

How often do you consume alcoholic beverages? □ Daily □ Weekly □ Monthly □ Infrequently □ Never

How often do you engage in recreational drug use? □ Daily □ Weekly □ Monthly □ Infrequently □ Never

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

____

RELATIONSHIP INFORMATION

Are you currently in a romantic relationship? □ YES □ NO If yes, length of time: _____________

If yes, on a scale of 1-10 (with 1 poor and 10 exceptional), how would you rate your relationship? ____

Have either of you threatened to separate or divorce (if married) as a result of the current relationship concerns? □ YES □ NO If yes, who? □ ME □ PARTNER □ BOTH OF US

Do you misuse/overuse alcohol or drugs? □ YES □ NO Does your partner? □ YES □ NO

Have you ever struck, physically restrained, used violence against or injured your partner? □ YES □ NO

Has your partner ever struck, physically restrained, used violence against or injured you? □ YES □ NO

If yes for either, who, how often and what happened? ____

____

Check each of the following symptoms you are currently or have experienced within the past six (6) months:

□ Affection	□ Holding the other back	□ Sexual Issues	□ Agreeing on Chores	□ Housing
□ Closeness	□ Showing Appreciation	□ Guilt/Shame	□ Solving Problems Together	□ In-laws
□ Finances	□ Partner's Cleanliness	□ Common Goals	□ Common Interests	□ Parenting
□ Relatives	□ Trusting Each Other	□ Communication	□ Use of Time	□ Jealousy
□ Friendships	□ Physical Fighting	□ Verbal Fighting	□ Having Fun Together	□ Recreation
□ Infidelity	□ Other ________________________			

Which of these symptoms do you wish to address in counseling at this time? Why now? _______________

____

FAMILY MENTAL HEALTH HISTORY

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 (e.g. father, grandmother, uncle, etc.)

Alcohol/Substance Abuse □ YES □ NO ________________________

Anxiety □ YES □ NO ________________________

Depression □ YES □ NO ________________________

Sexual Abuse □ YES □ NO _______________________

Domestic Violence □ YES □ NO ________________________

Eating Disorders □ YES □ NO ________________________

Obesity □ YES □ NO ________________________

Obsessive Compulsive Behavior □ YES □ NO ________________________

Schizophrenia □ YES □ NO ________________________

Suicide Attempts □ YES □ NO ________________________

ADDITIONAL INFORMATION:

Are you currently employed? □ YES □ NO

If yes, what is your current employment situation? ____

Do you enjoy your work? Is there anything stressful about your current work? ____________________

____

Do you consider yourself to be spiritual or religious? □ YES □ NO

If yes, describe your faith or belief: ____

____

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

____

IN CASE OF EMERGENCY CONTACT:

NAME: ____ PHONE: ______________________________

RELATIONSHIP (friend, family member, etc.): ____