



CLIENT INTAKE FORM

Please provide the following information for my records. Leave blank any questions you would rather not answer. Information you provide here is held to the same standards of confidentiality as therapy.

Please print this form, complete it as thoroughly and legibly as possible, and bring it with you to your first appointment. Alternatively, you may arrive early and complete it in the office waiting room before your first appointment. Allow 30 minutes for completion.

CONTACT INFORMATION & DEMOGRAPHICS

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

Address: _____
(Number) (Street) (Apt.)

(City) (State) (Zip)

Phone: _____
(Home) (Mobile) (Work)

Email: _____

Birth Date: ____ / ____ / ____ Age: _____

Gender: Male Female Other _____

Sexual Orientation:
 Bisexual Gay Heterosexual Lesbian
 Questioning Other _____

Race: African American/Black American Indian/Alaska Native Asian/Asian American
 Caucasian/White Hispanic/Latino Multiracial Native Hawaiian/Pacific Rim
 Other _____

Religion: Agnostic/Atheist Buddhist Catholic Christian Hindi Jewish
 Muslim Other _____



RELATIONSHIP INFORMATION

Current Relationship: Single Dating Engaged Cohabiting Partners
 Married Separated Divorced Widowed

Name of Partner: _____ Duration of Relationship: _____

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

Names & Ages of Children:
From Current Relationship: _____
From Prior Relationship(s): _____

Others Living in Your Home: _____

OCCUPATIONAL INFORMATION

Work Status: Employed Full-Time Employed Part-Time Self-Employed
 Homemaker Retired Disabled Student Unemployed

Occupation: _____

Highest Education Completed:
 Elementary High School/GED Some College College Graduate
 Technical School Graduate School Post-Graduate School

PSYCHOTHERAPEUTIC INFORMATION

Are you currently receiving psychiatric services, professional counseling or psychotherapy elsewhere?
 No
 Yes, with _____
(current provider's name) (start date)

Have you had previous psychotherapy?
 No
 Yes, with _____
(previous provider's name) (dates)

Are you currently taking prescribed psychiatric medication (antidepressants or others)?
 No
 Yes _____
(medication name) (dosage) (condition) (provider)

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(medication name) (dosage) (condition) (provider)



HEALTH AND SOCIAL INFORMATION

How is your current physical health?

- Poor Unsatisfactory Satisfactory Good Very good

Please list persistent physical symptoms or health concerns (e.g. chronic pain, hypertension, etc.).

Are you having problems with your sleep habits?

- No
 Yes Sleeping too little Sleeping too much Poor quality sleep Disturbing dreams

How many times/ week do you exercise? _____ Approximately how long each time? _____

Are you having any difficulty with your appetite or eating habits?

- No
 Yes Eating less Eating more Binging Restricting

Have you experienced significant weight change in the last 2 months?

- No
 Yes Gained _____ pounds Lost _____ pounds

Do you regularly use alcohol? No Yes

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

Do you use caffeine?

- No
 Yes Coffee Hot Tea Iced Tea Soda

Cups per day: _____

Do you use tobacco products?

- No
 Yes Cigarettes Cigars Chewing Tobacco

Quantity per day: _____

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

Drugs used include: _____

Please describe any significant life changes or stressors that occurred in the past year:

FAMILY MENTAL & SOCIAL HEALTH HISTORY

Has anyone in your immediate and/or extended family experienced difficulty with the following?
Please circle your response, then list the affected family member(s) -- e.g., Sibling, Parent, Uncle, etc.

<u>Difficulty</u>	<u>Response</u>	<u>Family Member</u>
Depression	yes/no	_____
Bipolar Disorder	yes/no	_____
Anxiety Disorders	yes/no	_____
Panic Attacks	yes/no	_____
Schizophrenia	yes/no	_____
Alcohol/Substance Abuse	yes/no	_____
Eating Disorders	yes/no	_____
Learning Disabilities	yes/no	_____
Trauma History	yes/no	_____
Suicide Attempt	yes/no	_____
Suicide Completion	yes/no	_____
Legal Problems	yes/no	_____
Divorce	yes/no	_____
Incarceration	yes/no	_____
Abuse as Victim	yes/no	_____
Abuse as Perpetrator	yes/no	_____

Comments:

SYMPTOM ASSESSMENT

Are you currently experiencing -- or have you experienced in the past -- difficulty with any of the following? Please circle your responses, and elaborate in the comments section.

Individual Concerns

Extreme depressed mood	yes/no	current/past
Wild Mood Swings	yes/no	current/past
Rapid Speech	yes/no	current/past
Extreme Anxiety	yes/no	current/past
Panic Attacks	yes/no	current/past
Phobias	yes/no	current/past
Sleep Disturbances	yes/no	current/past
Hallucinations	yes/no	current/past
Unexplained Losses of Time	yes/no	current/past
Unexplained Memory Lapses	yes/no	current/past
Alcohol/Substance Abuse	yes/no	current/past
Frequent Body Complaints	yes/no	current/past
Eating Disorder	yes/no	current/past
Body Image Problems	yes/no	current/past
Repetitive Thoughts (e.g., Obsessions)	yes/no	current/past
Repetitive Behaviors (e.g., Hand-Washing)	yes/no	current/past
Cutting/Self-Harm	yes/no	current/past
Uncontrollable Rage	yes/no	current/past
Homicidal Thoughts	yes/no	current/past
Suicidal Thoughts	yes/no	current/past
Suicide Attempt	yes/no	current/past

Comments:



Relational Concerns

Relationship Problems	yes/no	current/past
Extra-relational Affair	yes/no	current/past
Physical Abuse	yes/no	current/past
Sexual Abuse	yes/no	current/past
Emotional Abuse	yes/no	current/past
Parenting or Co-parenting Issues	yes/no	current/past

Comments:

Sexual Concerns

Low Sex Drive	yes/no	current/past
Anorgasmia/Lack of Orgasm	yes/no	current/past
Dyspareunia/Painful Intercourse	yes/no	current/past
Vaginismus/Spasms Preventing Penetration	yes/no	current/past
Premature Ejaculation/Rapid Ejaculation	yes/no	current/past
Delayed Ejaculation/Retarded Ejaculation	yes/no	current/past
Erectile Dysfunction	yes/no	current/past
Compulsive Sexual Behavior/Sex Addiction	yes/no	current/past
Sexually Transmitted Infection(s)	yes/no	current/past
Fertility Problems	yes/no	current/past
Abortion	yes/no	current/past
Incompatible couple sex drive	yes/no	current/past

Comments:



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?

What else would you like me to know about you?

Client Signature (Client's Parent/Guardian if client is under 18)

Date