CLIENT INTAKE FORM

Name: _____ Sex: M F

Age: ____ DOB: _____

Street Address: _____

City:_____ State:_____ Zip Code: _____

Home Phone:_____ Cell: _____

Email: _____

INSURANCE INFORMATION:

Insurance Company: _____

Contract #: _____ Group #:_____

Co-pay: $_____

Name of Primary Insured:_____

Birthdate of Primary Insured:_____

If you wish for therapist to coordinate with your PCP please sign consent below:

Primary Care Physician:_____

Address: _____ _____ ____ _____
(street address) (city) (state) (zip)

Phone: _____

X _____
Signature

TREATMENT HISTORY

Are you currently receiving psychiatric services, professional counseling or psychotherapy elsewhere?
( ) no ( ) yes

Have you had previous psychotherapy?
( ) no ( ) yes, with (previous therapist's name)_____

Are you currently taking prescribed psychiatric medication (antidepressants or others)?
( ) yes ( ) no

If yes, please list: _____

Prescribed by: _____

In the last year, have you experienced any significant life changes or stressors? If yes, please explain:
_____
_____

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MENTAL HEALTH INFORMATION

Have you ever experienced any of the following?

Depressed mood	**Yes / No**
Mood swings	**Yes / No**
Rapid speech	**Yes / No**
Anxiety	**Yes / No**
Panic attacks	**Yes / No**
Phobias	**Yes / No**
Sleep disturbances	**Yes / No**
Hallucinations	**Yes / No**
Unexplained losses of time	**Yes / No**
Unexplained memory lapses	**Yes / No**
Alcohol/substance abuse	**Yes / No**
Frequent body complaints	**Yes / No**
Eating disorder	**Yes / No**
Body image problems	**Yes / No**
Repetitive thoughts (e.g. obsessions)	**Yes / No**
Repetitive behaviors (e.g. frequent checking, hand washing	**Yes / No**
Homicidal thoughts	**Yes / No**
Suicidal thoughts or attempts	**Yes / No If attempt, when?**

Have you had any suicidal thoughts recently?
( ) no ( ) yes date: _____

Have you had them in the past?
( ) no ( ) yes date: _____

FAMILY HISTORY

Who were you raised by? _____

How many siblings do you have? _____

Do you currently have contact with family members? _____

What are your current relationships like with family members?
_____
_____

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	Yes / No	Family member
Depression	Yes / No	
Bipolar disorder	Yes / No	
Anxiety disorder	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 attempts	Yes / No	
Chronic illness	Yes / No	
Mental Health Hospitalization	Yes / No	

HEALTH INFORMATION

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

_____

Are you currently on medication to manage a physical health concern? If yes, please list:
_____
_____

Are you currently seeing more than one medical health specialist? ( ) yes ( ) no

If yes, please list: _____

When was your last physical? _____

Are you having any problems with your sleep habits? ( ) yes ( ) no

If yes, check where applicable:
( ) Sleeping too little ( ) Sleeping too much ( ) Poor quality sleep
( ) Disturbing dreams ( ) other _____

How many times per week do you exercise? _____

Are you having any difficulty with appetite or eating habits? ( ) no ( ) yes

If yes, check where applicable: ( ) Eating less ( ) Eating more ( ) Bingeing ( ) Restricting

Have you experienced significant weight change in the last 2 months? ( ) no ( )yes

SUBSTANCE USE

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 _____

How often do you engage in recreational drug use?
( ) daily ( ) weekly ( ) monthly( ) rarely ( ) never

Do you smoke cigarettes or use other tobacco products? ( ) yes ( ) no

RELATIONSHIP HISTORY

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 (10 being the highest quality), how would you rate your current relationship? ___

Have you ever been divorced: ( ) no ( ) yes when: _____

Do you have any children? ( )no ( ) yes
names and ages:_____
_____
_____

EDUCATIONAL HISTORY

What is the highest grade you completed in school? ( ) High School ( ) Trade School ( ) College

How did you do in school? _____

OCCUPATIONAL INFORMATION

Are you currently employed? ( ) no ( ) yes

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

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

Please list any work-related stressors, if any _____

LEGAL INFORMATION

Have you ever had any legal problems or arrests ( ) no ( ) yes

If yes please explain: _____
_____

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 have learned?

_____

_____

What are your goals for therapy?

- _____
- _____
- _____
- _____

_____ _____

Client Signature **Date**