CLIENT INTAKE

Name: _____ Today's Date: _____

Date of Birth: _____ Age: _____ Gender: Male ◯ Female ◯

Home Address: _____

Mailing Address: _____

Home Phone: _____ Cell Phone: _____

Fax: _____ Email Address: _____

Relationship Status:
◯ Single ◯ Married ◯ Domestic Partnership ◯ Separated ◯ Divorced ◯ Widowed

Family Demographics: Name Age Occupation/School

Spouse/Partner: _____

Children: _____

_____

_____

_____

Other: _____

_____

What are the concerns that bring you to therapy? _____

_____

_____

_____

When did your first start experiencing these concerns or issues? _____

What are you hoping to accomplish in therapy? _____

_____

_____

_____

Prior therapy? Yes. No. When? _____ Where? _____

Was your prior therapy helpful and if so, how? _____

_____

Have you ever been given a mental health diagnosis? Yes. No. If so, what what was that diagnosis? _____

Have you ever been hospitalized for psychiatric reasons? Yes. No.
If yes, where and when? _____

Have you ever had suicidal thoughts or attempts to harm yourself? Yes. No.
If so, when _____

Are you currently suicidal? Yes. No.

Do you use drugs or alcohol? Yes. No. If yes, how much, how often? _____

_____

Have you ever received treatment for drugs or alcohol? Yes. No. If so, when and where?

_____

Do you have any health issues? _____

_____

Current medications: _____

Family Mental Health History – please list any family members who have had mental health issues / diagnoses or suicidal attempts you are aware of, and indicate the relationship of the person to yourself:

_____

_____

Please check any of the following issues that apply to you:

Abandonment	Abuse	Alcohol	Alienation
Anger	Avoidance	Anxiety	Appetite +/-
Blended Family	Body Image	Bonding	Boundaries
Codependency	Communication	Concentration	Compulsive Eating
Compulsions	Current crisis	Depression	Disability
Distractible	Domestic Violence	Divorce	Drugs
Emotionally Numb	Eating Disorder	Emptiness	Employment issues
Enabling	Family Conflict	Fatigue	Fears
Financial stress	Grief	Guilt	Hallucinations
Hopelessness	Hyperactivity	Inactivity	Impulsivity
Inhibitions	Irritability	Intrusive thoughts or dreams	
Infidelity	Jealousy	Legal issues	Marital
Medical	Memory loss	Mood swings	Pain
Panic attacks	Rage	Rationalizations	Rejection
Relationships	Self Absorption	Self-Esteem	Sexual Abuse
Shame	Social Skills	Sibling conflict	Sleep
Suicidal (Thoughts or Actions)		Trust	Weight issues

Trauma/Life Threatening Event (explain:_____)

Other (explain: _____)