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Client Intake Form

Today's Date:_____

Name:	DOB:	Age:
Address:	Gender:	Marital Status:
Home Phone:	May I leave a message on your home phone? Y or N	
Cell Phone:	May I leave a message on your cell phone? Y or N	
Preferred method of contact (circle one): Home Cell	May I contact you via text? Y or N	
Email Address:	May I contact you by e-mail? Y or N	

Who can I contact in case of emergency:

Name:	Relationship:
Address:	Phone Number:

Mental Health Information

What are the reasons you are seeking therapy at this time? _____

_____

_____

_____

Have you been in therapy in the past? Yes ☐ No ☐ If so, specify date, reason for counseling, and your experience.

_____

_____

_____

List any past or current psychiatric conditions: _____

_____

_____

_____

Are you under the care of a psychiatrist? Y/N	Psychiatrist's name and phone number:

List any past or current psychiatric medications:

Medication:	Dosage:	Purpose:	How long?

Have you ever attempted suicide? Yes ☐ No ☐ If yes, please describe circumstances, method, and time frame:

_____

_____

_____

Have you in the past or do you currently have suicidal thoughts? Yes ☐ No ☐ If yes, please describe:_____

_____

_____

Have you ever been hospitalized for a psychiatric issue? Yes ☐ No ☐ If yes, please describe circumstances and time frame:_____

_____

_____

Have you had or currently have thoughts of urges to harm others? Yes ☐ No ☐ If yes, please describe:_____

_____

_____

Please circle any of the following you have experienced in the past six months:

Increased appetite	*Decreased appetite*	*Trouble Concentrating*
Difficulty sleeping	*Excessive sleep*	*Low motivation*
Isolation from others	*Fatigue/low energy*	*Low self-esteem*
Depressed mood	*Tearful or crying spells*	*Anxiety*
Fear	*Hopelessness*	*Panic*

Other_____

Medical Information

List any past or current medical conditions: _____

_____

_____

_____

List any past or current medical medications:

Medication:	Dosage:	Purpose:	How long:

Do you have a primary care physician? Y/N	Physician's name and phone number:

Cultural/Spiritual Information:

Is your culture important to you? Yes ☐ No ☐ If yes, please explain how?

_____

_____

_____

How do you identify your race/ethnicity?_____

_____

Do you consider yourself to be religious and/or spiritual? Yes ☐ No ☐ If yes, describe your faith and/or beliefs: _____

_____

_____

Is it important to you to have your culture and spirituality included in your therapy? Yes ☐ No ☐

Relationships and Family History

If you are in the relationship, please describe the nature of the relationship and months or years together._____

_____

_____

Describe your current living situation. Do you live alone, with family, etc._____

_____

_____

Please identify and explain any past or current significant relationships with immediate and extended family members._____

_____

_____

_____

Is there a history of mental illness in your family? Yes ☐ No ☐ Please describe._____

_____

_____

Education and Occupation Information

Highest level of education:	Do you have a degree? If so, what is your degree in?
Currently a student? Yes ☐ No ☐ If so, what is your course of study?	

What is your occupation:	Current employer:
Do you enjoy your occupation? (circle one): Yes ☐ No ☐	

Substance History

Do you drink alcoholic beverages? Yes ☐ No ☐ If yes, describe type, amount, frequency.

Have you in the past or currently use, abuse, or experiment with illegal drugs? Yes ☐ No ☐

If yes, describe type, amount, frequency.

Do you currently smoke cigarettes? Yes ☐ No ☐ If yes, how many do you smoke in a day?

What else would you like me to know?

What goals do you wish to accomplish during this therapy process?