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CLIENT INTAKE FORM

Name: _____ Date: _____

Address: _____

City: _____ Zip Code: _____

Birth date: _____ Age: ____ Gender: _____

Are you currently employed? ☐ Yes ☐ No

Employer _____

Position _____

How long have you been with current employer? _____

How were you referred to me?

_____

_____

Name of insurance company (if using insurance):

I.D. #: _____ Group #: _____

Phone number of insurance company: _____

If you want to use insurance it is your responsibility to have your insurance company send me the authorization before I can see you.

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc)? ☐ Yes ☐ No

(If *yes*, list therapists you have seen and approximate dates):

List any substance abuse treatment or inpatient treatment you have had and the dates:

How often do you engage in recreational drug use?

☐ Daily ☐ Weekly ☐ Monthly ☐ Infrequently ☐ Never

Please indicate which of these substances you currently use:

Substance:	Amount used		How Often?
Alcohol		+	
Marijuana		+	
Cocaine		+	
or crack		+	
LSD		+	

Heroin _____+_____

Other_____ _____+_____

Please indicate if you are currently having or have had any of the following :

	Present	Past
Difficulty falling asleep or staying asleep	☐	☐
Sleeping too much	☐	☐
Change in appetite, weight loss or weight gain	☐	☐
Frequent Crying	☐	☐
Panic attacks or anxiety attacks	☐	☐
Thoughts of killing or hurting myself	☐	☐
Attempts to kill or hurt myself	☐	☐
Plans to kill or hurt myself	☐	☐
Problems concentrating	☐	☐
Periods of daily sadness lasting more than two weeks:	☐	☐
I startle easily	☐	☐
Periods of time when I seem to need very little sleep:	☐	☐
Often feel as if I am running like a motor	☐	☐

Can't stop remembering upsetting past events	☐	☐
Difficulty controlling my temper	☐	☐
I physically hurt other people	☐	☐

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 (father, grandmother, uncle, etc.)

		List Family Member
ADHD	☐ yes ☐ no	
Alcohol/Substance Abuse	☐ yes ☐ no	
Anxiety	☐ yes ☐ no	
Bipolar Disorder	☐ yes ☐ no	
Depression	☐ yes ☐ no	
Domestic Violence	☐ yes ☐ no	
Eating Disorders	☐ yes ☐ no	
Obsessive Compulsive Disorder:	☐ yes ☐ no	
Phobias/Panic Attacks	☐ yes ☐ no	
Schizophrenia	☐ yes ☐ no	

Suicide Attempts ☐yes ☐no

Have you ever experienced any traumas in childhood, adolescence or as an adult? If yes, can you give the nature of the trauma? (type of trauma):

FAMILY/RELATIONSHIP INFO

Relationship/Marital Status :

☐Domestic Partnership ☐Married ☐Single ☐Divorced ☐Widowed

Significant other's name and how long together

List names and ages (or birth order) of you and your siblings:

Names and ages of all children in your home:

Names and ages of all children not in your home:

Whom shall I contact in case of emergency?

Name:_____ Phone:_____

Relationship: _____

Why are you seeking therapy at this time?

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

What do you consider to be your strengths?

MEDICAL AND HEALTH HISTORY

Primary Care Physician: _____

Primary Care Physician's phone number: _____

Are you taking any prescription medication? ☐ Yes ☐ No

If yes, please all current medications and dosages:

Name of Medication: _____ Dosage: _____

Prescribing Doctor: _____

Name of Medication: _____ Dosage: _____

Prescribing Doctor: _____

Name of Medication: _____ Dosage: _____

Prescribing Doctor: _____

Name of Medication: _____ Dosage: _____

Prescribing Doctor: _____

How would you rate your current physical health?

☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very good

Please list all health problems or conditions: