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CLIENT INTAKE

Today's Date: _____

Please complete this form before our first session and bring it with you. Leave blank any question you would rather not answer. Information you provide here is held to the same standards of confidentiality as our therapy. Thank you!

Name: _____ Date of Birth: _____

Street, City, Zip: _____

Employer: _____

Name of guarantor for payment, if other than self: _____

Street, City, Zip: _____

Your Contact Information:

Home Phone: _____ OK to leave a message? ☐ Yes ☐ No

Cell Phone: _____ OK to leave a message? ☐ Yes ☐ No

Email: _____ May I email you? ☐ Yes ☐ No

Referred by: _____

In case of emergency, please contact:

Name: _____ Relationship: _____

Street, City, Zip: _____ Phone: _____

Signature: _____ **Date:** _____

SOCIAL AND OCCUPATIONAL:

Marital Status:

☐ Never Married ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

If you have children, please list their names and ages:

Name	Sex	Age	Living at home	If not at home, where are they living?
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	

Who else currently resides in your home (describe relationship to you)? _____

_____

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, how would you rate the quality of your relationship? (1 = poor, to 10 = wonderful): ____

Please feel to add a comment, if you wish: _____

_____

Do you consider yourself to be religious or spiritual? ☐ Yes ☐ No

Please share anything you would like about your faith and spiritual practice: _____

_____

_____

Are you currently employed? ☐ No ☐ Yes

If yes, what is your current employment situation? _____

Are you happy at your current position? ☐ Yes ☐ No

If no, please list any work-related stressors: _____

_____

HEALTH HISTORY:

How is your physical health at present? (Please check one)

☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very good

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

_____

Please list any current medications for medical conditions including dosages:_____

_____

Please check any symptoms of experiences you have had **in the past month**.

☐ Difficulty falling asleep
☐ Difficulty staying asleep
☐ Difficulty getting out of bed
☐ Not feeling rested in the morning
☐ Poor quality of sleep
☐ Disturbing dreams

Average hours of sleep per night: _____

☐ Persistent loss of interest in previously enjoyed activities
☐ Withdrawing from other people
☐ Spending increased time alone
☐ Depressed mood
☐ Feeling numb
☐ Rapid mood changes
☐ Irritability
☐ Anxiety
☐ Panic attacks
☐ Frequent feelings of guilt
☐ Avoiding people, places, activities or specific things
☐ Difficulty leaving your home
☐ Fear of certain objects or situations (i.e., flying, heights, bugs)

Describe: _____

☐ Worthlessness
☐ Hopelessness
☐ Sadness
☐ Helplessness
☐ Fear
☐ Feeling or acting like a different person

☐ Changes in eating/appetite
☐ Eating less
☐ Eating more
☐ Use of laxatives (for non-therapeutic purpose)
☐ Voluntary vomiting
☐ Binge eating
☐ Excessive exercise to avoid weight gain
☐ Are you trying to lose weight? _____lbs
☐ Weight gain: _____ lbs
☐ Weight loss: _____ lbs

- ☐ Difficulty catching your breath
- ☐ Unusual sweating
- ☐ Increased energy
- ☐ Tremor
- ☐ Frequent worry
- ☐ Racing thoughts
- ☐ Difficulty concentrating or thinking
- ☐ Flashbacks
- ☐ Thoughts about harming or killing *yourself*
- ☐ Increased muscle tension
- ☐ Easily startled, feeling "jumpy"
- ☐ Decreased energy
- ☐ Dizziness
- ☐ Physical sensations that feel unusual
- ☐ Intrusive memories
- ☐ Large gaps in memory
- ☐ Nightmares
- ☐ Thoughts about harming or killing *someone else*

- ☐ Feeling as if you were outside yourself, detached, observing what you are doing
- ☐ Feeling puzzled as to what is real or unreal
- ☐ Persistent, repetitive, intrusive thoughts, impulses or images
- ☐ Unusual visual experiences such as flashes, lights or shadows
- ☐ Hearing voices when no one else is present
- ☐ Feeling that your thoughts are controlled or placed in your mind

- ☐ Difficulty problem solving
- ☐ Dependency on others
- ☐ Inappropriate expression of anger
- ☐ Difficulty or inability to say "no" to others
- ☐ Sense of lack of control
- ☐ Abusive relationship
- ☐ Concern about sexuality
- ☐ Difficulty meeting role expectations
- ☐ Manipulation of others to fulfill our own desires
- ☐ Self-mutilation/cutting
- ☐ Ineffective communication
- ☐ Decreased ability to handle stress
- ☐ Difficulty expressing emotions

Please describe any other symptoms or experiences you are observing: _____

_____

_____

Are you *currently* receiving psychiatric services, professional counseling or psychotherapy elsewhere?

☐ Yes ☐ No If yes, name of provider: _____

Have you had *previous* psychotherapy?

☐ No ☐ Yes Name of previous therapist: _____

Reason for seeking help: _____

Are you *currently* taking prescribed psychiatric medication (antidepressants or others)?

☐ Yes ☐ No If yes, please list with dosages: _____

If no, have you been *previously* prescribed psychiatric medication?

☐ Yes ☐ No If yes, please list with dosages: _____

Have you been hospitalized for psychiatric reasons?

☐ No ☐ Yes If yes, please describe giving dates and reason for hospitalization: _____

_____

_____

Have you ever attempted suicide?

☐ No ☐ Yes If yes, please describe circumstances including age at time of attempt:

_____

_____

_____

Have you had suicidal thoughts recently? (Please check one)

☐ Frequently ☐ Sometimes ☐ Rarely ☐ Never

Have you had them in the past? (Please check one)

☐ Frequently ☐ Sometimes ☐ Rarely ☐ Never

SUBSTANCE USE (*This information is entirely confidential):*

Do you drink alcohol? ☐ No ☐ Yes If yes, age of first use: _____

How often do you have a drink containing alcohol?

☐ Never ☐ Monthly or less ☐ 2-4 times a month ☐ 2-3 times week ☐ 4 or more times a week

How many standard drinks containing alcohol do you have on a typical day when drinking?

☐ 1 or 2 ☐ 3 or 4 ☐ 5 or 6 ☐ 7 to 9 ☐ 10 or more

How often to you have six or more drinks on one occasion?

☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

During the past year, how often have you found that you were not able to stop drinking once you had started?

☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

During the past year, how often have you failed to do what was normally expected of you because of drinking?

☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

During the past year, how often have you needed a drink in the morning to get yourself going after a heavy drinking session?

☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

During the past year, how often have you had a feeling of guilt or remorse after drinking?

☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

During the past year, have you been unable to remember what happened the night before because you had been drinking?

☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

Have you or someone else been injured as a result of your drinking?

☐ No ☐ Yes, but not in the past year ☐ Yes, during the past year

Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested you cut down?

☐ No ☐ Yes, but not in the past year ☐ Yes, during the past year

Other Substances:

Drug	**Ever used?**	**Age at 1st use**	**Age at last use**	**Approximate use in last 30 days (e.g., 2 days out of 30)**
Marijuana	☐ Yes ☐ No			
Cocaine	☐ Yes ☐ No			
Crack	☐ Yes ☐ No			
Heroin	☐ Yes ☐ No			
Methamphetamine	☐ Yes ☐ No			
Ecstasy	☐ Yes ☐ No			
Other: _____	NA			

Do you use tobacco (including chew)? ☐ No ☐ Yes If yes, how often? _____

FAMILY HISTORY:

Father: Name: _____ Age: ____ ☐ Living ☐ Deceased

Cause of death: _____

If deceased, HIS age at time of his death _____ YOUR age at time of his death _____

Occupation: _____ Health: _____

Frequency of contact: _____ Are you/have you been close? ☐ Yes ☐ No

Use three (or more, if you like) adjectives *to describe him*: _____

_____

Use three (or more, if you like) adjectives *to describe your relationship with him*: _____

_____

Mother: Name: _____ Age: ____ ☐ Living ☐ Deceased

Cause of death: _____

If deceased, HER age at time of her death _____ YOUR age at time of her death _____

Occupation: _____ Health: _____

Frequency of contact: _____ Are you/have you been close? ☐ Yes ☐ No

Use three (or more, if you like) adjectives *to describe her*: _____

_____

Use three (or more, if you like) adjectives *to describe your relationship with her*: _____

_____

Are your parents married to each other? ☐ Yes ☐ No

If no, your age when they separated/divorced: _____

Brothers and Sisters:

Name	Sex	Age	Living where?	Are you close to him/her?
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

During your childhood did you live any significant period of time with anyone other than your natural parents?

☐ No ☐ Yes If so, please give the person's name and relationship to you: _____

_____

Please indicate if there is a history of any of the following **for you or anyone in your biological family**. If yes, describe the family member's relationship to you (e.g., parent, sibling, maternal or paternal grandparent, maternal or paternal aunt/uncle, child, etc.).

Anxiety	☐ No ☐ Yes	_____
Depression	☐ No ☐ Yes	_____
Bipolar Disorder	☐ No ☐ Yes	_____
Alcohol/Substance Abuse	☐ No ☐ Yes	_____
Schizophrenia	☐ No ☐ Yes	_____
Eating Disorder	☐ No ☐ Yes	_____
Physical/Sexual Abuse	☐ No ☐ Yes	_____
Suicide	☐ No ☐ Yes	_____
Learning Disability	☐ No ☐ Yes	_____
Attention Deficit Disorder/ Hyperactivity	☐ No ☐ Yes	_____

PERSONAL ASSESSMENT:

On average, how many times per week do you exercise (list different activities)? _____

_____

What activities do you engage in for recreation and relaxation? _____

_____

Are you able to participate in these activities as often as you would like? ☐ Yes ☐ No

If not, what are the barriers? _____

What do you consider to be some of your strengths? _____

_____

_____

What do you most like about yourself? _____

_____

_____

What are effective coping strategies that you have learned? _____

_____

_____

What are your goals for therapy? _____

_____

_____

_____

Please feel free to write anything else you would like to share about yourself, your history, and your current circumstances: _____

_____

_____

_____

Thank you very much for taking the time to share this information!