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### CLIENT INTAKE FORM

Please provide the following information for my records. Leave blank any question you would rather not answer. Information you provide here is held to the same standards of confidentiality as our therapy.  
Please print out this form and bring it to your first session.

**Name:** \_\_\_\_\_  
(Last) (First) (Middle Initial)

**Address:**  
\_\_\_\_\_  
(Street and Number)  
\_\_\_\_\_  
(City) (State) (Zip)

**Home Phone:** ( ) - **Cell/Work Phone** ( ) -

I give permission to be called at: HOME: Yes/No CELL/WORK :Yes/No

Special Instructions: \_\_\_\_\_.

I understand that if I have caller ID, the counselors name will be disclosed.  
Please Initial \_\_\_\_\_

**Email:** \_\_\_\_\_ May I email you? Yes/No

**Birth Date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_ **Age:** \_\_\_\_\_

**Gender:**  Male  Female

**Marital Status:**  
 Never Married  Partnered  Married  Separated  Divorced  
 Widowed

**Number of Children:** \_\_\_\_\_ **Ages:** \_\_\_\_\_

**Referred by:**  
\_\_\_\_\_

**Current reason for seeking therapy:** \_\_\_\_\_  
\_\_\_\_\_

**\*Only fill out the following section if client is a minor**

**Name of parents/guardian**

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(Last) (First) (Middle)

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(Last) (First) (Middle)

Parents are: (circle) Married Separated Divorced Never Married

In the event of parents' separation and/or divorce, the court has set the following custody stipulations:

Physical Custody: (circle) mother father full shared other

Legal Custody: (circle) mother father full shared other

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Signature (Client's Parents/Guardian if under 18) Date

**HEALTH AND SOCIAL INFORMATION**

1. How is your physical health at present? ( please circle)

Poor Unsatisfactory Satisfactory Good Very good

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

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3. Are you having any problems with your sleep habits?  No  Yes

If yes, check where applicable:

Sleeping too little  Sleeping too much  Poor quality sleep  
 Disturbing dreams  Other \_\_\_\_\_

4. How many times per week do you exercise? \_\_\_\_\_

5. Are you having any difficulty with appetite or eating habits?  No  Yes

If yes, check where applicable:  Eating less  Eating more  Binging

Have you experienced significant weight change in the last 2 months?

No  Yes

6. Do you regularly use alcohol?  No  Yes  
In a typical month, how often do you have 4 or more drinks in 24-hours? \_\_\_\_\_

7. How often do you engage in recreational drug use?  
 Daily  Weekly  Monthly  Rarely  Never

8. Have you had suicidal thoughts recently?  
 Frequently  Sometimes  Rarely  Never

Have you had them in the past?  
 Frequently  Sometimes  Rarely  Never

9. 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 current relationship? \_\_\_\_\_

Do you currently feel safe in this relationship? Yes/No

10. In the last year, have you experienced any significant life changes or stressors:  
\_\_\_\_\_  
\_\_\_\_\_

**Have you ever experienced:**

Extreme depressed mood	yes/no
Wild Mood Swings	yes/no
Rapid Speech	yes/no
Extreme 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
Suicide Attempt	yes/no



Anxiety Disorders	yes/no
Panic Attacks	yes/no
Schizophrenia	yes/no
Substance Abuse	yes/no
Eating Disorders	yes/no
Learning Disabilities	yes/no
Trauma History	yes/no
Suicide Attempts	yes/no

**OTHER INFORMATION**

What do you consider to be your strengths?

What do you like most about yourself?

What are effective coping strategies that you've learned?

What are your goals for therapy?