## **Client Intake Form**

**Client Name: -**

**Date of first appointment:**

Please take your time in providing the following information. The questions are designed to help us begin to understand you so that our time together can be as productive as possible.

All information provided is confidential.

Referred by:

 Medical Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Insurance Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Our website

Counselling Directory

 Psychology Today

 Friend/Family: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you previously received any type of mental health services?

Yes

No

If yes, which of the following:

Counselling/Psychotherapy

Medication

Outpatient Hospitalisations Inpatient Hospitalisation

If yes, please provide:

Name of provider or facility: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dates of treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Briefly, what brings you to therapy now?

When did your problem first start?

Within the last:

 30 days

 6--12 months

 2 years

 During adolescence During childhood

What areas of your life have been affected because of this problem?

Are you currently experiencing overwhelming sadness, grief or depression?

 Yes

 No

If yes, for approximately how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently experiencing anxiety, panic attacks or have any phobias?

 Yes

 No

If yes, when did you begin experiencing this? ------------------------

Please describe any major losses or traumas you have experienced:

What significant life changes or stressful events have you experienced recently? What would you like to accomplish out of your time in therapy?

# Family History

Where were you born? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Where did you grow up? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 City

 Suburbs

 Country

Who did you live with while growing up? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mother's occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Father's occupation? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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.).

|  |  |  |
| --- | --- | --- |
| **Condition** | **Please circle** | **List Family Member** |
|  Alcohol/Substance Abuse |  yes/no |   |
|  Anxiety |  yes/no |   |
|  Depression |  yes/no |   |
|  Domestic Violence |  yes/no |   |
|  Sexual Abuse |  yes/no |   |
|  Eating Disorders |  yes/no |   |
|  Obesity |  yes/no |   |
|  Obsessive Compulsive Disorder |  yes/no |   |
|  Schizophrenia | yes/no  |   |
|  Suicide Attempts |  yes/no |   |
|  Other diagnosed mental health condition? | yes/no: which was--- |  |

**Marital Status:**

 Never Married

 Domestic Partner

 Married

 Separated

 Divorced -- For how long?

 Widowed

If married, how long have you been married for? -------

On a scale of 1-10 (best), how would you rate your relationship? \_\_\_\_\_

Are you currently in a romantic relationship?

 Yes -- How long? \_\_\_\_\_\_\_

 No

On a scale of 1-10 (best), how would you rate your relationship? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any Children? Yes: -------- No:--------

# Physical Health

Please list any medications, herbs, or supplements. Be sure to include the condition, as some medications are prescribed for off-label use. Continue on the back if needed or provide a separate list. If you have a complicated medical profile, please supply supporting documentation to be able to facilitate a comprehensive understanding of your health.

|  |  |  |  |
| --- | --- | --- | --- |
| **Medication/Supplement** | **Dosage** | **Condition** | **Date Began/Stopped** |
|   |   |   |   |
|   |   |   |   |
|   |   |   |   |
|   |   |   |   |
|   |   |   |   |
|   |   |   |   |
|   |   |   |   |

Prescribing provider and contact information:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Specialty: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Facility: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone, email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How would you rate your current physical health?

 Poor

 Unsatisfactory

 Satisfactory

 Good

 Very Good

Please list any specific health problems you are currently experiencing:

How would you rate your current sleeping habits?

 Poor

 Unsatisfactory

 Satisfactory

 Good

Very Good

If you are having problems, in which phase of sleep are you experiencing issues?

Falling asleep

Staying asleep

Awakening early

Sleep apnea

Please list any other specific sleep problems you are currently experiencing:

How many times per week do you generally exercise? \_\_\_\_\_\_\_\_\_\_\_\_ What types of exercise do you participate in:

Are you currently experiencing any chronic pain?

 No

 Yes

If yes, please describe:

Please describe current use of alcohol, cigarettes, and/or recreational drugs:

Please describe previous use of alcohol, cigarettes, and/or recreational drugs:

# Additional Information

What do you enjoy about your work (full-time homemaker included)? If retired, what did you enjoy about your work?

What do you find particularly stressful about your current or previous work?

What do you enjoy doing in your free time?

What do you do to relax?

Do you consider yourself to be spiritual or religious? If yes, please describe your faith or belief:

What do you consider to be some of your strengths?

What do you consider to be some of your weaknesses?

Thank you for taking the time to complete this form.