

**PSYCHOTHERAPY CLIENT INTAKE FORM**

Disclaimer: Thank you for your interest in being a client of [CLINIC/THERAPIST NAME]. This form is used to collect information about new clients and for internal purposes only. The information you provide is confidential and will be treated accordingly.

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| **PERSONAL INFORMATION** |

**Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Birthdate**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Age**: \_\_\_\_\_

**Gender**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Marital status**: [ ]  Never married [ ]  Partnered [ ]  Married [ ]  Separated [ ]  Divorced [ ]  Widowed

**Referred by (if any)**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Number of children**: \_\_\_\_\_ **Ages**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Phone Number**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ May we leave a message? [ ]  Yes [ ]  No

**Email**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ May we email you?\* [ ]  Yes [ ]  No

\*NOTE: Emails may not be confidential

**Emergency contact**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone** **Number**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are you currently receiving psychological services, professional counseling, psychiatric services, or any other mental health services?** [ ]  Yes [ ]  No

-If so, specify your reason for changing: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are you currently taking any psychiatric prescription medication?** [ ]  Yes [ ]  No

-If yes, please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you been prescribed psychiatric prescription medication in the past?** [ ]  Yes [ ]  No

-If yes, please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you been psychiatrically hospitalized in the past?** [ ]  Yes [ ]  No

-If yes, please list dates and locations: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **GENERAL HEALTH INFORMATION** |

**Provide the name, address, and telephone number of your primary care physician**:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**How is your physical health?** [ ]  Poor [ ]  Unsatisfactory [ ]  Satisfactory [ ]  Good [ ]  Very good

**Please list any persistent physical symptoms or health concerns**:

**Are you on any medication for physical/medical issues?** [ ]  Yes [ ]  No-If yes, please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are you having any problems with your sleep habits?** [ ]  Yes [ ]  No
-If yes, select the options that apply: [ ]  Sleep too much [ ]  Sleep too little [ ]  Poor quality
[ ]  Disturbing dreams [ ]  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are there any changes or difficulties with your eating habits?** [ ]  Yes [ ]  No
-If yes, select the options that apply: [ ]  Eating less [ ]  Eating more [ ]  Bingeing [ ]  Restricting
[ ]  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you experienced a weight change in the last two months?** [ ]  Yes [ ]  No

**Do you exercise regularly?** [ ]  Yes [ ]  No
-If yes, how many days per week do you exercise? \_\_\_ How much time per session? \_\_\_\_\_\_\_

**Do you consume alcohol regularly?** [ ]  Yes [ ]  No
-In one month, how many times do you have four or more drinks in a 24-hour period? \_\_\_

**How often do you engage in recreational drug use?** [ ]  Daily [ ]  Weekly [ ]  Monthly [ ]  Rarely [ ]  Never

**What kinds of recreational drugs do you use?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are you currently in a romantic relationship?** [ ]  Yes [ ]  No
-If yes, how long have you been in this relationship? \_\_\_\_\_\_\_\_\_\_\_\_\_
-On a scale of 1 – 10 (10 being great), how would you rate the quality of this relationship? \_\_\_\_

**In the last year, have you had any major life changes (e.g., new job, moving, illness,
relationship change, etc.)?**

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| **SYMPTOMS** |

**Check any that apply to you**:

[ ]  Depressed mood
[ ]  Panic attacks
[ ]  Memory lapse
[ ]  Relationship problems
[ ]  Mood swings
[ ]  Phobias
[ ]  Trouble planning
[ ]  Hallucinations
[ ]  Rapid speech
[ ]  Repetitive behaviors
[ ]  Sleep disturbance
[ ]  Eating difficulties
[ ]  Suicidal thoughts
[ ]  Anxiety
[ ]  Time loss
[ ]  Body complaints
[ ]  Homicidal thoughts
[ ]  Excessive worry
[ ]  Alcohol/drug abuse
[ ]  Traumatic event

**Have you felt depressed recently?** [ ]  Yes [ ]  NoIf yes, for how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you had any suicidal thoughts recently?** [ ]  Yes [ ]  No-If yes, how often? [ ]  Frequently [ ]  Sometimes [ ]  Rarely

**Have you ever had suicidal thoughts in your past?** [ ]  Yes [ ]  No
-If yes, how long ago? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
-How often did you have these thoughts? [ ]  Frequently [ ]  Sometimes [ ]  Rarely

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| **FAMILY MENTAL HEALTH HISTORY** |

**Have any of your family members had any of the following issues?** If so, specify the family member affected.

[ ]  Depression ­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
[ ]  Suicide \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
[ ]  Anxiety disorder \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
[ ]  Bipolar personality disorder \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
[ ]  Panic attacks \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
[ ]  Alcohol/substance abuse \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
[ ]  Eating disorder \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
[ ]  Trauma \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
[ ]  Domestic violence \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
[ ]  Sexual abuse \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
[ ]  Obesity \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
[ ]  Obsessive-compulsive disorder \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
[ ]  Schizophrenia \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **PERSONAL DETAILS** |

**Do you practice a religion?** [ ]  Yes [ ]  NoIf yes, what’s your faith? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are you currently employed?** [ ]  Yes [ ]  No-If yes, who’s your employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ What’s your position? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are you happy in your current position?** [ ]  Yes [ ]  No **Does your work make you stressed?** [ ]  Yes [ ]  No-If yes, what are your work-related stressors? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **List your strengths and what you like most about yourself**:

 **List areas you feel you need to develop**:

**What are some ways you cope with life obstacles and stress?**

**What are your goals for therapy/what would you like to accomplish?**

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| **ACKNOWLEDGMENT** |

By signing below, I am acknowledging that I have chosen to receive mental health services in the form of evaluation and psychotherapy from the clinic. My decision is voluntary, and I understand that I may terminate these services at any time. I also understand that during the course of treatment, I may need to discuss material of an upsetting nature in order to resolve my problems. Further, I understand it cannot be guaranteed that I will feel better after completion of treatment.

Patient signature: [\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_](https://esign.com/) Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Guardian signature (if required): [\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_](https://esign.com/) Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_