

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