PSYCHOTHERAPY CLIENT INTAKE FORM

Disclaimer: Thank you for your interest in being a client of .
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.

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: _____

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.)?

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 ☐ No
If 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

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 _____

PERSONAL DETAILS

Do you practice a religion? ☐ Yes ☐ No If 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?

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: _____ Date: _____

Print name: _____

Guardian signature (if required): _____ Date: _____

Print name: _____