

**THERAPIST CLIENT INTAKE FORM**

Disclaimer: Thank you for your interest in being a client of [CLINIC'S 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.

**Today’s Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **CLIENT INFORMATION** |

**Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Birth date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Current age**: \_\_\_\_\_\_

**Address**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **City**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Zip**: \_\_\_\_\_\_\_\_\_\_\_\_\_

**Cellphone**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Is it okay to:  Phone?  Leave a message?  Text?

**Secondary phone**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Is it okay to:  Phone?  Leave a message?  Text?

**Email**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *(Please be aware that emails may not be confidential)*

-Is it okay to email you regarding your appointment?  Yes  No

**Preferred method of contact**:  Cellphone  Secondary phone  Email  Mail

Other (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency contact name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to you: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **DEMOGRAPHIC INFORMATION** |

**Gender**:  Female  Male  Transgender  Other (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Ethnicity**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Prefer not to answer

**Sexual** **orientation**:  Bisexual  Heterosexual  Lesbian/gay  Questioning

Other (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Religious/cultural identity**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Prefer not to answer

**Relationship** **status**:  Single  Partnered  Married  Separated  Divorced  Widowed

Other (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   
-If applicable, please list your current or former partner or spouse’s age and occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

-If applicable, how long have you been/were you in this relationship? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Check the highest degree you’ve earned**:  GED  High school  Associate’s degree

Bachelor’s degree  Master’s degree  Doctoral degree

-Current/former schools: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

-Field(s) of study: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are you currently employed?**  Yes  No

-If yes, list your current occupation and employer. If no, list your former occupation and employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are you a veteran?**  Yes  No

-If yes, what branch of military? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time of service: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Who referred you to the clinic/therapist?** Self  Friend  Family member  School  Hospital  Clergy/religious leader

Medical provider  Mental health provider

-If referred by a physician or mental health provider, please provide their name and contact information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **HEALTH HISTORY** |

**Primary** **care** **physician name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Psychiatrist name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Other health professional name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**When was your last physical exam?** \_\_\_\_\_\_\_\_\_\_\_\_

**How is your physical health?**  Poor  Unsatisfactory  Satisfactory  Good  Excellent

**Have you had any serious accidents or injuries?**  Yes  No

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

**Please describe any medical issues or hospitalizations you’ve had**:

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

**Do you regularly take any prescribed medications, over-the-counter drugs, supplements, or alternative remedies to treat a medical condition?**  Yes  No

-Psychiatric medications?  Yes  No

-If yes, please list any medications you are currently taking, the condition for which the medication is taken, and the prescribing physician (if applicable):

**Are you having problems with your sleeping habits?**  No problems  Sleeping too much  Sleeping too little  Poor quality of sleep  Disturbing dreams  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**How many times a week do you exercise?**  One or less  Two to four  Five or more

-For about how long do you exercise at a time? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are you currently having difficulty with your appetite or eating habits?**  No difficulty

Eating less  Eating more  Bingeing  Restricting  Significant weight gain or loss

-Please describe the nature of your eating habits or weight change:

**Do you have any problems or worries about your sexual functioning?**

No concerns  Lack of desire  Performance problem  Sexual impulsiveness

Difficulty maintaining arousal  Worried about STDs  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you received counseling services in the past?**  Yes  No

-If yes, please explain, including when, with whom, and whether you found it helpful:

**Are you currently receiving psychiatric services, professional counseling, or psychotherapy elsewhere?**  Yes  No

-If yes, please specify the mental health provider’s name and phone number:

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

**Have you ever been assessed for psychological or learning issues by a therapist, school counselor, or other provider?**  Yes  No

-If yes, please explain, including when and by whom, and the findings/diagnosis:

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

-If yes, please list what medications, the dosage, and when taken:

**Were the medications helpful?**  Yes  No

**Have you ever been hospitalized for psychiatric reasons?**  Yes  No

-If yes, please specify the reasons for past hospitalization:

Psychological problems  Suicidal thoughts/attempt  Dangerousness to others

Drugs/alcohol  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Was the hospitalization helpful?**  Yes  No

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| **FAMILY AND SOCIAL INFORMATION** |

**Please list the members of your family to whom you are close (not including any children), and specify their name, relationship to you, living or deceased, age (or age at the time of death), and occupation**:

**Do you have children?**  Yes  No

-If yes, please list their names, living or deceased, age (or age at the time of death), and gender (indicate if they are step, foster, or adopted):

**Do you have full custody of your children?**  Yes  No

-If no, describe the custody arrangement: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Any family history of mental illness, substance abuse, or learning difficulties?**

Yes  No

-If yes, please provide a brief explanation:

**Besides family members, approximately how many people can you count on right now for friendship and emotional support?**

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| **PRESENTING CONCERNS** |

**Briefly describe why you’re seeking therapy:**

**Is there any additional information about you (e.g., current difficulties, special circumstances, or challenges within your family, relationships, educational or work environment) that would be helpful for us to know?**

**Approximately how long have these concerns been bothering you?**

Couple days  A week  A month  Many months  A year  Many years  Most of my life

**How much do these concerns interfere with your**:

Daily routine:

Emotional well-being:

Relationships/activities:

Work/school:

Very little -  1  2  3  4  5 - Severely

Very little -  1  2  3  4  5 - Severely

Very little -  1  2  3  4  5 - Severely

Very little -  1  2  3  4  5 - Severely

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| **ACKNOWLEDGMENT** |

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

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

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

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