THERAPIST 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.

Today's Date: _____

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: _____

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: _____

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

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?

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:	Very little - ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 - Severely
Emotional well-being:	Very little - ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 - Severely
Relationships/activities:	Very little - ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 - Severely
Work/school:	Very little - ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 - Severely

ACKNOWLEDGMENT

Signature: _____ Date: _____

Print Name: _____

Guardian Signature (if required) _____ Date: _____

Print Name: _____