# 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 what brings you to this clinic:**

**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: _____