Client Intake Form

General Information

Name | Date of Birth | Age

Address

City | State | Zip Code

Phone # | Email

Is it ok to leave messages at this phone number? ☐ Yes ☐ No May we contact you via email? ☐ Yes ☐ No

Would you like to be added to our email list? ☐ Yes ☐ No

Emergency Contact Name | Phone #

Race: ☐ White ☐ Black/African American ☐ Asian ☐ Latinx/Hispanic ☐ Native American ☐ Multi-racial

Birth sex: ☐ Female ☐ Male ☐ Intersex ☐ Prefer not to disclose

Gender: ☐ Female ☐ Male ☐ Non-binary ☐ Transgender ☐ Prefer not to disclose

Preferred pronouns

Spirituality

Family Information

Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Widowed ☐ Divorced ☐ Separated ☐ _____

Spouse/Partner | Age | Lives with you? ☐ Y ☐ N

How satisfied are you with your relationship? ☐ Very Satisfied ☐ Satisfied ☐ Neutral ☐ Unsatisfied ☐ Very Unsatisfied

Do you have children? ☐ Yes ☐ No If no, please skip to the next section.

Child | Age | Lives with you? ☐ Y ☐ N

Child | Age | Lives with you? ☐ Y ☐ N

Child | Age | Lives with you? ☐ Y ☐ N

Child | Age | Lives with you? ☐ Y ☐ N

Family History

Who were you raised by?

How many siblings do you have?

Please describe your relationship with your parents/caregivers:

Please describe names, ages, and respective relationships with your siblings:

If there are any circumstances from your childhood that you'd like to elaborate on, please do so here:

Support System

Do you have a support system? ☐ Yes ☐ No

Please explain:

What is your current living situation?

Is your home environment safe? ☐ Yes ☐ No

If no, please explain why:

Employment/Education Status

Employer/School

Occupation/Years in School

Please check all that apply:

- ☐ Disabled
- ☐ Employed Full Time
- ☐ Employed Part Time
- ☐ Retired
- ☐ Unemployed
- ☐ Student

What is your highest level of education completed?

- ☐ Less Than High School
- ☐ High School/GED
- ☐ Associates Degree
- ☐ Some College
- ☐ Bachelor's Degree
- ☐ Post Graduate Degree

Mental Health History

Have you experienced any of the following in the past 90 days? Please check all that apply:

- ☐ ADHD
- ☐ Anger/Rage
- ☐ Anxiety
- ☐ Death in Family
- ☐ Depression
- ☐ Hallucinations
- ☐ Hospitalization
- ☐ Obsessive/Intrusive Thoughts
- ☐ Mood Swings
- ☐ Panic/Phobia
- ☐ Paranoia/Delusions
- ☐ Poor Sleep Patterns
- ☐ Racing Thoughts
- ☐ Self Injury
- ☐ Suicide Attempt
- ☐ Thoughts of Harming Others
- ☐ Violence
- ☐ Weight Gain/Loss

Have you experienced abuse? ☐ Yes ☐ No

If yes, please explain:

Have you ever been admitted to the hospital for mental health reasons? ☐ Yes ☐ No

If yes, please explain:

Is there any family history of mental health problems or suicide (attempts)? ☐ Yes ☐ No

If yes, please explain:

Have you had therapy in the past? ☐ Yes ☐ No If yes, was it helpful? ☐ Yes ☐ No

Previous therapist Dates seen

Medical History

Are you currently taking any medications? ☐ Yes ☐ No

If yes, please list:

Have you had any surgeries or operations? ☐ Yes ☐ No

If yes, please list:

Do you currently have any medical problems? ☐ Yes ☐ No

If yes, please list all symptoms and treatments you are undergoing:

Do you experience physical pain that causes mental health issues? ☐ Yes ☐ No

Physician Phone Number

Permission to contact physician? ☐ Yes ☐ No

Stressors

What stressors are you dealing with or have you dealt with in the past? Please check all that apply:

- ☐ Alcohol/Drug Abuse
- ☐ Attempted Suicide
- ☐ Death
- ☐ Debilitating Injuries/Disabilities
- ☐ Divorce
- ☐ Financial Crisis/Unemployment
- ☐ Frequent Relocations
- ☐ Legal Problems
- ☐ Physical/Sexual Abuse
- ☐ Psychiatric Illness
- ☐ Serious illness
- ☐ Other _____

Personal History

What symptoms are you dealing with? Please check all that apply:

- ☐ Appetite Problems
- ☐ Concentration Problems
- ☐ Energy Levels
- ☐ Flashbacks
- ☐ Hopelessness
- ☐ Low Interest/Motivation
- ☐ Mood Swings
- ☐ Nightmares
- ☐ OCD Symptoms
- ☐ Panic Attacks
- ☐ Thoughts of Self-harm/Suicide
- ☐ Trouble Sleeping
- ☐ Other _____

How long have you been dealing with these?

What effect do these have on your life? ☐ Minimal ☐ Mild ☐ Moderate ☐ Severe

Habits & Lifestyle

Do you regularly drink alcohol? ☐ Yes ☐ No

If yes, how often:

Are you dealing with any addictions? ☐ Yes ☐ No

If yes, please explain:

How often do you engage in recreational drug use? ☐ Never ☐ Rarely ☐ Monthly ☐ Weekly ☐ Daily

Do you consider your alcohol/drug use a problem? ☐ Yes ☐ No ☐ Unsure

Do you exercise regularly? ☐ Yes ☐ No

If yes, please describe what you do and how often:

Do you have hobbies? ☐ Yes ☐ No

If yes, what are they and how often do you do them?

What do you do for fun?

Legal Summary

Have you or are you dealing with any of the following legal issues? Please check all that apply:

- ☐ Custody/Divorce
- ☐ Fraud
- ☐ Substance Abuse
- ☐ Driving Offenses
- ☐ Immigration
- ☐ Violence

Have you ever been imprisoned? ☐ Yes ☐ No

If yes, please explain:

Are you court ordered for services? ☐ Yes ☐ No If no, please skip to the next section.

Are you assigned to a probation officer or case worker? ☐ Yes ☐ No

If yes, please list them here: Name: Phone Number:

Will you require progress reports for legal authorities? ☐ Yes ☐ No

Goal Information

Please answer the following questions to the best of your ability:

Why are you seeking treatment at this time?

What would you like to change about yourself or your circumstances?

What gives you hope, purpose, and meaning?

What do you hope to get from treatment?