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CLIENT INTAKE FORM

Client Name: _____

Please describe your main reason(s) for seeking services at this time? _____

CURRENT RELATIONSHIP STATUS

- Single Common Law Separated Widowed Cohabiting
 Married Divorced Polyamory Other _____

How is your current relationship (if applicable)? _____

IMMEDIATE FAMILY INFORMATION (please complete all applicable)

Relationship	Name(s)	M/F	Date of Birth	Living with You?
Mother(s)				
Father (s)				
Partner/Spouse				
Children				

SIGNIFICANT OTHERS (brothers, sisters, grandparents, step-relatives, half-relatives, etc.
 Please specify relationship)

Relationship	Name	M/F	Date of Birth	Living with You?

OTHER FAMILY INFORMATION (parents separated, divorced, remarried, family members who are deceased, other special circumstances): _____

CURRENT ISSUES

Have you struggled with the any of the following issues? Check all that apply.

Issue	Current	Past	Issue	Current	Past
Stress/Trouble coping			Suicidal thoughts		
Sleep problems			Trauma history or symptoms		
Grief			Dissociation		
Depression			Mental confusion		
Anxiety			Eating disorder		
Panic attacks			Addictive behaviors		
Fear/phobias			Alcohol concerns		
Interpersonal problems			Drug use		
Sexual issues			Self-harm		
Sexuality or gender			Other: (specify)		

Have you ever received a formal diagnosis from a doctor for any of the above or for any other relevant issue? Do you agree with the diagnosis? _____

If so, who made the diagnosis? _____

Have you ever attempted suicide? Yes No

If yes, when: _____

Has a family member ever attempted/committed suicide? Yes No

If yes, who: _____

Have you ever engaged deliberately in self-harm behavior(s)? Yes No

MEDICATIONS

Are you currently prescribed any medications? Yes No

If yes, please list all of your currently prescribed medications below.

Name of Medication	Date Started	Dose (mg)	Purpose	Name of Prescriber

VITAMINS / NATURAL REMEDIES

Are you currently taking any natural remedies or vitamins? Yes No

If yes, please list all of them below.

Name of Vitamin/Remedy	Date Started	Dose (mg)	Purpose

FAMILY MENTAL HEALTH HISTORY

Has anyone in your family experienced difficulties with the following? (Check any that apply and list family member, e.g., spouse, sibling, parent, uncle, grandparent, etc.):

Difficulty	Experienced	Family Member(s) Affected
Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Bipolar Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Anxiety Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Panic Attacks	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Schizophrenia	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Alcohol/Substance Abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Eating Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Learning Disabilities	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Trauma History	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Suicide Attempts	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Other (specify):	<input type="checkbox"/> Yes <input type="checkbox"/> No	

PSYCHOTHERAPY/TREATMENT HISTORY

Do you currently have an individual therapist, psychiatrist, or any other person helping you with mental or emotional health concerns? Yes No

Have you ever received psychotherapy/psychiatric treatment? Yes No

Have you ever received alcohol or drug use treatment? Yes No

Have you ever been hospitalized for mental health issues? Yes No

*If yes to receiving any of the above services, as best as you can, please list **current and past** providers in the table below.*

PSYCHOTHERAPY/PSYCHIATRIC TREATMENT			
Name of Provider/Treatment Program	Current Primary Provider?	Date Started/Ended Treatment	Response to Overall Experience
	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor
	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor
	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor
ALCOHOL OR DRUG USE TREATMENT			
	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor
	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor
	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor
PSYCHIATRIC HOSPITALIZATION			
	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor
	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor
	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor

EDUCATION

	Completed	Partial	
Elementary	<input type="checkbox"/>		Grade ____
High School/GED	<input type="checkbox"/>		Grade ____
College/University	<input type="checkbox"/>	<input type="checkbox"/>	Program/Degree _____ / ____
Graduate School	<input type="checkbox"/>	<input type="checkbox"/>	Program/Degree _____ / ____
Other Training	_____		
Special Circumstances	(learning disabilities, gifted, etc.) _____		

EMPLOYMENT

Are you currently employed? No Yes
 If yes, who is your current employer/position? _____
 If yes, are you happy at your current position? _____

ALCOHOL/SUBSTANCE USE

What is your average number of alcoholic drinks you have in a week? _____
 Do you use any substances/drugs recreationally? _____
 If so, please name which substances: _____

SLEEP HABITS

Are you having any problems with your sleep? Yes No
 If yes, check where applicable:
 Sleeping too little Sleeping too much Poor quality sleep Disturbing dreams
 Other _____

PHYSICAL HEALTH

How is your overall physical health at present? (please check one)
 Very good Good Okay Poor Bad

Issue	Current	Past	Issue	Current	Past
Muscle / bone injuries			Varicose veins		
Accidents / falls			Heart / circulatory problems		
Sprain / strain			High / low blood pressure		
Arthritis / tendonitis			Allergies		
Abdominal / digestive issues			Blood clots		
Numbness / tingling			Infectious disease		
Sinus congestion			Cancer / tumors		
Pregnancy			Dental / jaw problems		
Surgeries			Immune system issues		
Scar tissue			Thyroid issues		
Asthma / lung conditions			Uro-gynecological / pelvic issues		
Chronic pain			Chronic fatigue		
Fibromyalgia			Diabetes		
Muscle aches / pain			Headaches / migraines		

If comfortable, please provide additional details about the boxes checked in the table above:

EXERCISE

What do you engage in for exercise? _____

How often do you exercise? _____

SPIRITUALITY / RELIGION

How important to you are spiritual matters?

Not at all Little Moderate Very much

How important to you are religious matters?

Not at all Little Moderate Very much

LEISURE/RECREATIONAL ACTIVITIES

Describe special areas of interest or hobbies (e.g., art, books, writing, crafts, physical fitness, sports, outdoor activities, spiritual activities, walking, exercising, diet/health, meditation, yoga, traveling, etc.)

Activity	How Often Now?	How Often in the Past?

What do you consider to be your strengths? _____

What are effective coping strategies that you currently use? _____

Describe your support network (friends, family, community supports)? _____

When were things better for you? What was different then? _____

What are your goals for treatment? _____

On a scale of 0 to 10 (where 10 means things are going well and 0 means the opposite), please circle where you are today on this scale:

0 1 2 3 4 5 6 7 8 9 10

Any additional information that would assist us in understanding your concerns or problems:

What do we need to know about you to work successfully with you? _____

Client Signature: _____

Date Form Completed: _____

Many thanks! We look forward to supporting you in service of your goals.