

### CLIENT INTAKE FORM

Client Name: \_\_\_\_\_ Age: \_\_\_\_\_

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

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

#### CURRENT RELATIONSHIP STATUS

- Single       Common Law       Separated       Widowed       Cohabiting
- Married       Divorced       Polyamorous       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	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 / 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



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

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**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? \_\_\_\_\_

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What are effective coping strategies that you currently use? \_\_\_\_\_

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

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When were things better for you? What was different then? \_\_\_\_\_

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What are your goals for treatment? \_\_\_\_\_

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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 me in understanding your concerns or problems:

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What do I need to know about you to work successfully with you? \_\_\_\_\_

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Client Signature: \_\_\_\_\_

Date Form Completed: \_\_\_\_\_

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