CLIENT INTAKE FORM

INTAKE ASSESSMENT & CLIENT INFORMATION

Demographic Information

Name: _____ Preferred Name: _____ Date: _____

DOB (MM/DD/YYYY): _____ Age: _____ Birthplace: _____

Gender: _____ Race: _____ Ethnicity: _____

Therapy Desired (circle): Individual Couples Family Group

Address: _____

Name of parent(s)/guardian(s) who have legal custody of minor:
_____

* *Address if parent/guardian lives in another residence:*
Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number(s): _____
Is it okay to leave a voicemail? *YES* *NO*

Email Address: _____
Is it ok to email you? *YES* *NO*

Information on group services needed:
YES *NO*

Local emergency contact I am authorized to communicate with:
Person 1: Name & Phone Number: _____
Relationship with you: _____
Person 2: Name & Phone Number: _____
Relationship with you: _____

How were you introduced to us? _____
(Church, referral, counselor, medical doctor, family or friend, internet, Psychology Today, social media, Theravive)

More of What Brings You In for Therapy?

Has anyone urged you to come here? If so? When?

Briefly tell me about the concerns that have brought you here.

Have you ever seen a therapist and if so, who? where? how long? for what concerns?

Would you be interested in group therapy? YES NO

If you are interested in group therapy, for what topics or issues (please check or circle those that apply)

Eating disorders
Work/Academic Issues
Child abuse (i.e. emotional, sexual, physical)
Depression
Stress/Anxiety
Phobias
Alcohol/Other Drug Abuse
Relationship Concerns
Family Issues (i.e. divorce, alcoholism, domestic violence)
Pregnancy Issues
Spiritual Concerns
Suicidal Thoughts
Pornography
Sexual Identity Issues
Sexual Assault/Rape
Death/Grief
PTSD
Racial Abuse

What are the 3 biggest concerns you have right now? How long have each been going one?

1. _____
2. _____
3. _____

What solutions (helpful or unhelpful) have you tried to resolve the above concerns?

_____
_____

Have you had therapy or mental health services in the past? If so, please provide the treatment providers' names, dates of service, what you were seen for, and results.

_____

_____

What are your expectations from counseling and from the provider?

_____

_____

List concrete changes you would like to see happen during the course of counseling services:

_____

_____

What other things would you like to see change in your life and your family's life?

_____

_____

Do you foresee any obstacles to achieving your goals/changes?

_____

_____

If You Currently Experience Any of the Following Symptoms (Required)
Please rate them using the key below
Never = 0, Seldom = 1, Often = 2, Always = 3

Symptom	Never = 0	Seldom = 1	Often = 2	Always = 3
Difficulty concentrating				
Crying				
Missing work/classes				
Feeling helpless				
Feeling uptight				
Feeling afraid				
Lying to others				
Feeling out of control				
Feeling of self-doubt				
Injuring self				
Nervous around others				
Memory loss or blackout				
Difficulty sleeping				
Stealing				
Anger				
Eating binges				
Other drug use				
Guilt Feelings				
Withdrawing socially				

Sexual preoccupation				
Physical symptoms (i.e. headaches, digestive issues)				
Suicidal thoughts				
Other				

Please Use the Scale Below to Answer the Following Questions (Required)

Rate them using the key below

Not true at all = 1, Somewhat true = 2, Mostly true = 3, True to a great extent = 4

	Not true = 1	Somewhat true = 2	Mostly true = 3	True to a great extent = 4
My current concerns affect my success in life				
My current concerns affect my ability to interact and connect with others				
I am optimistic that I will be able to make some positive changes as a result of counseling.				

Medical Background

Have you ever received psychiatric or been admitted to the hospital for psychiatric services before?

YES NO

If yes, how long ago, with whom, for what, and results:

_____

_____

Many people have opinions on psychiatric medications, what are yours?

_____

_____

Do you have any allergies (food, environmental, medicinal, animal, etc.)

_____

_____

Any current or past medical issues, hospitalizations, accidents, injuries or surgeries? If yes, for what?

_____

_____

Are you presently under a physician's care? If so, for what?

_____

_____

List medications (over the counter & prescribed), nutritional or herbal supplements, alternative treatments (acupuncture, chiropractic, etc.) you are taking/doing and reasons:

_____

_____

For postpartum or pregnancy issues, tell us about the pregnancy of your child (full term, preemie, any complications during pregnancy or at birth, environment and situations during pregnancy and birth). Did you seek care for these issues? If yes, please explain.

_____

_____

Important Questions We Must Ask

Have you ever had thoughts of killing yourself? YES NO
If yes, please explain:

_____

_____

Have you ever planned on killing yourself? YES NO
If yes, please explain:

_____

_____

Have you ever attempted to kill yourself? YES NO
If yes, please explain:

_____

_____

Has anyone in your family or close to you died by suicide? YES NO
If yes, please explain:

_____

_____

Have you ever felt like you wanted to seriously hurt or kill someone else?
If yes, please explain: YES NO

_____

_____

Do you have weapons in your home or access to weapons? YES NO
If yes, who has access to them and what are the safety protocols around them?

_____

_____

Is there any past or present abuse or violence? YES NO
If so, please explain:

_____

_____

Are you currently using any illegal drugs or is the reason you are seeking therapy services substance-related?

_____

_____

Have you ever witnessed or experienced a trauma? Have reoccurring nightmares, or flashbacks, or avoid anything that is uncomfortable or painful? If so, please explain:

_____

_____

Are you concerned you may see or hear things that don't appear to be real? If so, please explain:

_____

_____

Have you been arrested, been involved with the justice system, or are engaging in behaviors that put you at risk? If so, please explain.

_____

_____

Do you have any concerns about your sexuality, gender, or sexual development?

_____

_____

Understanding Your Family

** Space left for therapist to draw family tree (genogram)*

Marital status:

Married Divorced Never Married Separated Domestic Partners Widowed

If separated or divorced, if so and how long and reason:

_____

_____

If you are divorced or separated, if you have children, who do they live with?

_____

_____

List 5 or more strengths of your family:

_____

_____

Is there anything that gets in the way of your family being the way you want it to be?

_____

_____

Name, relationship and description of relationship below:

Parent 1: _____

Parent 2: _____

Step-parents or parent's significant other:

_____

Children: Age, Name and Sex:

1. Child 1 _____
2. Child 2 _____
3. Child 3 _____
4. Child 4 _____

Other important relationships:

_____

_____

Does your family belong to any religious or spiritual groups? YES NO

If yes, what is your level of involvement?

_____

_____

Who else do you consider to be part of or supportive of your family (people or affiliations):

_____

_____

Is there anything else that you think is important for me to know about you or your family?

_____

_____

_____

_____