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— MENTAL HEALTH THERAPIST —
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# Client Intake Form

***Please Print Clearly***

Today's date: _____

Name: _____ Birthdate: _____ Age: _____

Name of parent/guardian (if under 18 years): _____

Address: _____

City: _____ State: _____ Zip Code: _____

Primary phone: _____ May we leave a message? YES NO

Secondary phone: _____ May we leave a message? YES NO

Referred by (if any): _____
If applicable, may we have permission to contact your referral source to thank them for the referral? YES NO

Current marital status:

- Never married
- Domestic Partnership
- Married
- Divorced/Separated
- Widowed
- Other _____

List the persons with whom you are now living, their ages, and their relationship to you: _____

_____

_____

_____

_____

Education: ____some high school ____high school graduate ____GED ____technical/trade
____some college ____college graduate ____post-graduate ____ other

Profession: _____ Employer: _____

Do you enjoy your work? Is there anything stressful about your job? _____

_____

_____

_____

**In case of emergency, I give permission to contact**:

Name: _____ Relationship: _____

Telephone: (home) _____ (work) _____ (cell) _____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

- No
- Yes, previous therapist/practitioner: _____

Current health status (circle one): excellent good fair poor Date of last physical exam: _____

Describe any presenting health concerns/illnesses: _____

_____

_____

_____

Are you currently taking any prescribed medication?

- Yes
- No

Please list: _____

_____

_____

_____

When possible, I like to coordinate care with your physician, psychiatrist, or other health care provider. May I have your permission to communicate with your primary care doctor, psychiatrist, or other health care professional?

- Yes
- No

If yes, please initial here: _____ Name of physician: _____

Do you drink alcohol more than once per week?

- No
- Yes

Has anyone ever expressed any concerns about your drinking?

- No
- Yes

If yes, please explain: _____

_____

_____

_____

Has your drinking ever negatively impacted your life in any way (i.e., relationships, health concerns, loss of employment, legal charges, etc.)?

- No
- Yes

If yes, please explain: _____

_____

_____

_____

How often do you engage in recreational drug use?

- Daily
- Weekly
- Monthly
- Infrequently
- Never
- Other _____

Are you currently involved in a romantic relationship?

- No
- Yes

If yes, for how long? _____

On a scale of 1-10, how would you rate your relationship? _____

Briefly describe any significant life changes or stressful events that you have experienced recently: _____

_____

_____

_____

_____

_____

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.):

| | Please Circle | List Family Member |
|---|---|---|
| Alcohol/Substance Abuse | yes/no | |
| Anxiety | yes/no | |
| Depression | yes/no | |
| Domestic Violence | yes/no | |
| Eating Disorders | yes/no | |
| Obesity | yes/no | |
| Obsessive Compulsive Behavior | yes/no | |
| Schizophrenia | yes/no | |
| Suicide Attempts | yes/no | |

Describe briefly what brings you into counseling: _____

_____

_____

_____

_____

_____

Rate how strongly you want to change your presenting problem(s):

(do not want to change) 1 2 3 4 5 6 7 8 9 10 (desperately want to change)

**Symptom Checklist (check all that apply):**

_____I am dissatisfied with my life and want a change
_____I am dissatisfied with the current state of my family life
_____I am dissatisfied in my relationship with my spouse or significant other
_____I am dissatisfied with, confused about or have questions regarding the sexual part of my life
_____I am dissatisfied with my interpersonal relationships in general
_____I am dissatisfied with my body
_____In the past few months I have thought about how I could end my life

**I have recently experienced:**

_____moodiness
_____change in appetite
_____racing thoughts
_____difficulty sleeping
_____unusual anger or irritability
_____change in sex drive
_____stomach trouble
_____mental confusion/disorientation
_____loneliness
_____inability to relax
_____resentment
_____decreased energy/motivation
_____anxious feelings
_____unusual fatigue
_____nightmares
_____feelings of hopelessness
_____bowel disturbances
_____feelings of sadness or loss

**In the last few weeks/months, I have done the following to cope with my problems:**

_____worked more than usual
_____binge eating
_____drank alcohol
_____used illegal drugs
_____refused to get out of bed
_____neglected my hygiene
_____isolated myself from people
_____misused prescription drugs
_____harmed myself by cutting, burning, etc.
_____used pornography
_____ignored my responsibilities
_____ acted sexual in an unusual way for me

**In my lifetime, I have experienced:**

_____the loss of a loved one
_____an abortion
_____ a traumatic event
_____divorce of my parents
_____divorce of my own
_____bullying
_____the death of a child
_____ abandonment by loved ones
_____ sexual abuse or assault
_____the death of a pet
_____feeling unloved by important people
_____being fired from a job
_____an addictive habit
_____mental, verbal, or physical abuse
_____the loss of someone by suicide
_____something else significant to me: _____

What do you consider to be some of your strengths? _____

_____

_____

_____

_____

_____

What do you consider to be some of your weaknesses/liabilities? _____

_____

_____

_____

_____

_____

What are your goals for counseling? What do you wish to accomplish? _____

_____

_____

_____

_____

_____

What specific concerns or anxieties do you have about counseling? _____

_____

_____

_____

_____

Is there anything else you'd like to share with me? _____

_____

_____

_____

_____

_____

Client Signature Date