CLIENT INTAKE FORM

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Date of first appointment:

Please take your time in providing the following information. The questions are designed to help me begin to understand you so that our time together can be as productive as possible. All information provided is confidential.

Referred by:

Medical Provider: _____

Insurance Provider: _____

My Website:

PsychologyToday

Friend/Family: _____

Other: _____

Have you previously received any type of mental health services?

Yes No If yes, which of the following: (Psychotherapy) (Medication) (Inpatient Hospitalization)

If yes, please provide: Name of provider or
facility:_____
Location:_____
Dates of treatment:_____
Reason for treatment:_____

Briefly, what brings you in today?

When did your problem first start? Within the last:

(30 days) (6--12 months) (2 years) (During adolescence) (During childhood)

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What areas of your life have been affected because of this problem?

Are you currently experiencing overwhelming sadness, grief or depression?

Yes
No

If yes, for approximately how long? _____

Are you currently experiencing anxiety, panic attacks or have any phobias?

Yes No If yes, when did you begin experiencing this? _____

Please describe any major losses or traumas you have experienced:

What significant life changes or stressful events have you experienced recently?

What would you like to accomplish out of your time in therapy?

Family History

Where were you born? _____

Where did you grow up? _____

Please Circle: (City) (Suburbs) (Country)

Please list your parents and siblings. Please use additional space on the back if needed.

Mother (Name, Age, If deceased, age and cause of death):
_____
_____

Father (Name, Age, If deceased, age and cause of death):
_____
_____

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Sibling (Name, Age, If deceased, age and cause of death):
_____
_____

Sibling (Name, Age, If deceased, age and cause of death):
_____
_____

Who did you live with while growing up? _____

Mother's occupation: _____

Father's occupation? _____

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.).

Alcohol/Substance Abuse yes/no

Anxiety yes/no

Depression yes/no

Domestic Violence yes/no

Sexual Abuse yes/no

Eating Disorders yes/no

Obesity yes/no

Obsessive Compulsive Disorder yes/no

Schizophrenia yes/no

Suicide Attempts yes/no

Other diagnosed mental health condition? yes/no

Marital Status (circle one):

(Never Married) (Domestic Partner) (Married) (Separated) (Divorced -- For how long?) (Widowed: Please provide your partners name and year deceased):

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If married, how long have you been married for and what is your partners name:

_____

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

Are you currently in a romantic relationship?

Yes -- How long? _____
No

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

Please list any children, their names, and ages:

Physical Health

Please list any medications, herbs, or supplements. Be sure to include the condition, as some medications are prescribed for off-label use. Continue on the back if needed, or provide a separate list. If you have a complicated medical profile, please supply supporting documentation to be able to facilitate a comprehensive understanding of your health.

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Prescribing provider and contact information:

Name:
_____

Specialty:
_____

Facility:
_____

Phone, email, or Fax:
_____

How would you rate your current physical health
(circle One)?

Poor
Unsatisfactory
Satisfactory Good
Very Good

Please list any specific health problems you are currently experiencing:

How would you rate your current sleeping habits
(circle one)?

(Poor) (Unsatisfactory) (Satisfactory) (Good) (Very Good)

If you are having problems, in which phase of sleep are you experiencing issues
(circle one)?

(Falling asleep) (Staying asleep) (Awakening early) (Sleep apnea) Please list any other specific sleep problems you are currently experiencing:

How many times per week do you generally exercise? _____

What types of exercise do you participate in:

Are you currently experiencing any chronic pain?

No Yes If yes, please
describe:

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Please describe current use of alcohol, cigarettes, and/or recreational drugs:

Please describe previous use of alcohol, cigarettes, and/or recreational drugs:

Additional Information

What do you enjoy about your work (full-time homemaker included)? If retired, what did you enjoy about your work?

What do you find particularly stressful about your current or previous work?

What do you enjoy doing in your free time? What do you do to relax?

Do you consider yourself to be spiritual or religious? If yes, please describe your faith or belief:

What do you consider to be some of your strengths?

What do you consider to be some of your weakness?