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CLIENT INTAKE FORM

Date:_____

General Information:

Full Name:_____

Preferred Name:_____ Preferred Pronoun: _____

Age: _____ Date of birth: _____

Current Mailing Address:_____

City, State, ZIP:_____

Phone:_____ May I leave a message here? Yes No

Email Address:_____ May I leave a message here? Yes No

Emergency Contact:_____ Phone number: _____

Sign here if I may contact this person in case of emergency: _____

How did you hear about my services?_____

Demographic Information:

Gender Identity: Male Female Genderqueer Trans Other: _____

Sexual Orientation: Gay Lesbian Bisexual Hetero Queer Other: _____

Ethnic Background: (Please check the category(s) that best describes you)

____ Asian or Pacific Islander ____Latino/Latina ____Chicano/Chicana

____ Black/African American ____White ____Native American

____ Mixed Heritage (Please Describe) _____

____ Other Ethnic Background (Please Describe) _____

Religious/Spirituality:

Religious/Spiritual Affiliation (Current): _____

Religious/Spiritual Heritage (Past): _____

How is religion or spirituality a resource in your life? _____

Relationship Information: (Check all that apply to you now)

Current Romantic Relationship Status

___Single __ Partnered __Polyamorous __Monogamous __Married __Separated/divorced __ Widowed

Are you content with your current relationship Status? Yes No Unsure If unsure or no, briefly explain:

_____

_____

With whom do you currently live? _____

Spouse/Partner Information:

If you are in a married or committed relationship:

- What is your Spouse/Partner's name(s)? _____
- Gender Identity: _____
- Race/Ethnicity: _____
- How long have you been together?_____
- How long have you known one another?_____
- Do you live together? _____
- Do you ever feel afraid of your partner? If yes please explain: _____

Does your Spouse/Partner:

- Support your desire to participate in psychotherapy?_____
- Earn an income? How?_____
- Abuse alcohol or drugs or have any chemical addictions?_____
- Have a history of psychiatric treatment? If yes, briefly explain:

  _____

Education Employment Information:

Last year of school completed: (circle one) 9 10 11 12 GED AA BA/BS Post Graduate Prof/Trade

Current employer: _____

Length of Current (un)employment: _____

Are you satisfied with your current employment Status? Explain: _____

_____

Presenting Issues:

Why are you seeking counseling now?:

_____

_____

_____

_____

How long have these concerns been causing you distress?

_____

Childhood and Family Information (PAST):

How would you describe your family during the time you were growing up? (Distant, argumentative, not close, healthy, etc.)

_____

_____

_____

Were your parents separated or divorced? If yes, what age were you when this happened?_____

Were you an only child? Yes No: If not what was your birth order or sequence amongst your siblings?_

_____

To whom in your family did you feel closest while growing up?

_____

_____

In your opinion, did any of your family or immediate relatives have an alcohol or drug problem while you were growing up? If yes, please say who and briefly indicated how this affected you.

_____

_____

In your opinion, did any of your family or immediate relatives have a problem with controlling anger or with violence and/or abusive behavior? If yes, briefly describe:

_____

_____

In your opinion, did any of your family or immediate relatives have other significant problems, including (circle one/please explain):Chronic Mental Illness, Disability, Severe Mental Illness, Suicide or Suicide Attempt(s), Criminal History, Severe Trauma: If yes, who and briefly explain:

_____

_____

Family Information (PRESENT):

Who are the people you think of when you think of "Family?"

_____

_____

Describe your feelings, impressions, hopes, and disappointments about your family now:

_____

_____

Please check the boxes below if you have had problems or concerns with any of the following:

I am experiencing…	Seldom	Often	Always	Never	For How Long
Frequent worry or tension					
Fear of many things					
Discomfort in social situations					
Feelings of guilt					
Phobias: fears of specific things					
Panic Attacks: Sweating, trembling, shortness of breath, heart palpitations					
Recurring distressing thoughts about a trauma or unpleasant event					
Avoiding people or places associated with that trauma or event					
Nightmares about traumatic experience					
I am Feeling…	Seldom	Often	Always	Never	For How Long
Decreased interest in pleasurable activities					
Social isolation, loneliness					

Suicidal thoughts					
Bereavement or feelings of loss					
Changes in Sleep (too much or not enough)					
Normal daily tasks require more effort					
Sad, hopeless, about future					
Excessive feelings of guilt					
Low Self Esteem					
I notice …	Seldom	Often	Always	Never	For How Long
I am angry, irritable, hostile					
I feel euphoric, energized, and highly optimistic					
I have racing thoughts					
I need less sleep than usual					
I am more talkative					
My moods Fluctuate: go up and down					
I Have …	Seldom	Often	Always	Never	For How Long
Memory problems or trouble concentrating					
Trouble explaining myself to others					
Problems understanding what others tells me					
Intrusive or Strange thoughts					
Obsessive thoughts					
I have …	Seldom	Often	Always	Never	For How Long
Risk taking behaviors					
Compulsive or repetitive behaviors					
Been acting without concern for consequences					
Been physically harming myself					
Been violent toward other(s)					
I use the Following Substances	Seldom	Often	Always	Never	For How Long
Alcohol					
Nicotine (Cigarettes)					

Marijuana					
Cocaine					
Opiates					
Sedatives					
Hallucinogens					
Stimulants					
Methamphetamines					
Others:					
My eating Involves	Seldom	Often	Always	Never	For How Long
Restriction of food consumption or food options					
Binging and purging					
Binge Eating					
Frequent/significant weight loss or gain					
Compensatory exercise behaviors					
Other food or exercise behaviors to manage weight, body:					
I have …	Seldom	Often	Always	Never	For How Long
Concerns about my sexual function					
Discomfort engaging in sexual activity					
Problems getting or keeping a job					
Struggles paying					
Concerns not covered in this list:					

Medical Information:

Current health care/medical provider(s):

Doctor's Name	Specialty: (medical, Psychiatrist, Physical Therapist) and Why you are seeing him or her or them	Address and Phone Number	Would you like to sign a release of Information to coordinate care?

Please list current medications and dosages:

Medication	Dosage	Taking for

Have you had any history of previous psychotherapy? Yes No

If yes, may we contact him or her for continuity of care?_____

Please describe your reasons for terminating therapy and/or changing therapists:

_____

_____

Any History of psychiatric treatment? If yes, please explain:

_____

_____

Therapeutic Goals:

What are the goals or outcomes you would like to reach while you are participating in counseling or psychotherapy?

_____

_____

What are you already doing to reach these goals or outcomes?

_____

_____

How will you know when you have reached these goals or outcomes? In other words, what will be happening in your life to tell you this?

_____

_____

What are some qualities about yourself that you like?

_____

_____

What do you like to do in your free time?

_____

_____

Is there anything else you would like to tell?

_____

_____

INSURANCE INFORMATION

Name of Insurance Co. _____

Subscribers Name _____

Subscribers Number _____ Group Number _____

Claims Address _____

Claims Phone Number_____

If Subscriber is other than yourself (partner, spouse, parent) please fill out below:

Name of Subscriber _____

SS# _____ DOB _____Phone# _____

Mailing Address: _____

Are you covered by any other insurance company Yes ____No ____

If yes, please list insurance company name, subscribers name, number, etc

Insurance Co _____ ph#_____

Subscriber Name _____ ph# _____

Insurance Co _____ ph# _____

Subscriber Name _____ ph# _____

If not yourself, who will be responsible for your bill?

Name _____Relationship to Patient _____

Billing Address with City and Zip Code _____

Phone numbers: Hm#_____ Wk#_____ Cellular# _____

Employer _____SS#_____