INTAKE

All the information provided in this intake is confidential and cannot be released without your consent.
It is important you take the time to answer the questions as thoroughly as possible.

Client Information

First Name ______________________________ Last Name ______________________________

Address ____

City ______________________________ State __________ Zip __________

Home Phone (_______) ______________________________ Can I Leave A Message? ❑ Yes ❑ No

Cell Phone (_______) ______________________ _____ Can I Leave A Message? ❑ Yes ❑ No

Email ______________________________ Social Security # _________-______-__________

Date of Birth _______/_______/________ Age: ___________

Emergency Contact ______________________________ Relationship ______________________________

Home Phone (_______) ______________________________ Cell Phone (_______) ______________________________

Occupation ____

Level of Education Completed ______________________________ Degree Obtained ______________________________

Employment/Education Status: (Check one)

❑ Employed ❑ Full Time ❑ Part Time Employer/School ______________________________

❑ Student ❑ Full Time ❑ Part Time ______________________________

❑ Unemployed ❑ Disabled ______________________________

Responsible Party Information

(if different than client)

First Name ______________________________ Last Name ______________________________

Relationship to Client ____

Address ____

City ______________________________ State __________ Zip __________

Home Phone (_______) ______________________________ Cell Phone (_______) ______________________________

Work Phone (_______) ______________________________ Social Security # _________-______-__________

Date of Birth ________/________/_________ Age ________________ Sex: ❑ Male ❑ Female

Referral Information

How did you hear about my services? ____

Is it okay to contact this person to thank them for the referral? ❑ Yes ❑ No Phone ______________________________

Signature of Client or Responsible Party ______________________________ Date ____________________

Family-of-Origin Information

Please include family member's name, age, living/deceased,
if deceased cause of death, how old you were at time of death and a description of the relationship.

Father____

Mother____

Stepfather____

Stepmother____

Sibling____

Sibling____

Sibling____

Current Family Structure

Please list all individuals who currently live with you. Include any information about custody arrangements for separated/divorced parents. Please include person's name, age, and a description of the relationship.

____

____

____

____

Marital/Relationship Information

Please include information regarding significant romantic relationships

Current Relationship Status (check one):

❑ Single ❑ Partnered ❑ Engaged ❑ Married ❑ Separated ❑ Divorced ❑ Widowed

Name of Partner/Spouse ____ Age ____________

How long have you been or were you:

❑ Married ____________ ❑ Living Together _______________ ❑ Going Out/Dating____________

How would you describe your relationship?____

____

Previous (check one): ❑ Spouse ❑ Partner Name _____________________________________

How long were you:

❑ Married ____________ ❑ Living Together _______________ ❑ Going Out/Dating____________

How would you describe your relationship?____

____

What caused the relationship to end? ____

____

Children

Name	Age	Sex	School/Occupation	Relationship Description

Medical/Mental Health Information

Please list all diseases, illnesses, important accidents and injuries, surgeries, hospitalizations, periods of loss of consciousness, convulsions/seizures and any other medical conditions your child has had.

Age Illness/Diagnosis Treatment Result

____

____

____

____

List all medications you are currently taking: (prescribed, over the counter, and others)

Medication Dosage Taken for When started Prescribed by

____

____

____

Please list current physician(s) or medical practitioners whose care you are under:

Name ______________________ Phone ______________

Name ______________________ Phone ______________

Name ______________________ Phone ______________

Has any member of your family been treated for

- Schizophrenia: ❑ Yes ❑ No If yes, who? ______________
- Bipolar Disorder: ❑ Yes ❑ No If yes, who? ______________
- Major Depression: ❑ Yes ❑ No If yes, who? ______________
- Substance Abuse or other Addictions: ❑ Yes ❑ No If yes, who? ______________

Other mental health issues in your family of origin ______________

____

Please list any major family health issues (include family member and issue) ______________

____

Have you ever received psychiatric or psychological services before? (check one): ❑ Yes ❑ No

(If yes, please list your age at the time of treatment, the length of treatment, the focus of treatment, if a diagnosis was given, what the diagnosis was, if you felt the diagnosis was accurate and the reason treatment was terminated.)

____

____

Have you (client) ever thought about, discussed or attempted suicide?): ❑ Yes ❑ No If yes, when? ______________

If so please describe ______________

____

Have you (client) ever been the victim of or witnessed:

- Domestic Violence/Abuse: ❑ Yes ❑ No If yes, who? ______________
- Physical Abuse: ❑ Yes ❑ No If yes, who? ______________
- Emotional Abuse: ❑ Yes ❑ No If yes, who? ______________
- Assault: ❑ Yes ❑ No If yes, who? ______________

If the answer to any of the above questions is “yes” was the abuse reported? ❑ Yes ❑ No

Is it still going on? ❑ Yes ❑ No

Symptoms/Problem Checklist

Please check any of the following problems/issues which you feel apply to you:

- ❑ Depression
- ❑ Hopelessness
- ❑ Loneliness
- ❑ Grief/Loss Issues
- ❑ Anxiety/Nervousness
- ❑ Fear
- ❑ Panic
- ❑ Suicidal Thoughts
- ❑ Racing Thoughts
- ❑ Separation Anxiety
- ❑ Obsessive Thoughts
- ❑ Compulsions
- ❑ Over Organized/Neat
- ❑ Messy
- ❑ Hoarding (difficulty getting rid of things)
- ❑ Temper/Anger
- ❑ Impulse Control Issues
- ❑ Irritability
- ❑ Self Control
- ❑ Concentration/Focus
- ❑ Memory Issues
- ❑ Self Criticism
- ❑ Low Self Esteem
- ❑ Guilt
- ❑ Tired/Weak
- ❑ Lack of Motivation
- ❑ Difficulty Making Decisions
- ❑ Overwhelm
- ❑ Issues with energy
  - ❑ Lack of Energy
  - ❑ Too Much Energy
- ❑ Difficulty with Change
- ❑ Life Transition Issues
  Specify ___________________
  ____
- ❑ Trauma
  Specify ___________________
  ____
- ❑ Issues with Sleep
  - ❑ Insomnia
  - ❑ Difficulty falling asleep
  - ❑ Difficulty staying asleep
  - ❑ Sleeping too much
  - ❑ Nightmares/Terrors
- ❑ Cultural/Religious Issues
- ❑ Work Issues
- ❑ School Issues
- ❑ Career Issues
- ❑ Financial Issues
- ❑ Legal Problems
  Specify ___________________
- ❑ Health Issue(s)
  Specify ___________________
  ____
- ❑ Health Issue with a Family Member
  Specify ___________________
  ____
- ❑ Disabilities
  Specify ___________________
  ____
- ❑ Learning Issues
  Specify ___________________
  ____
- ❑ Sexual Issues
  - ❑ Lack of Desire
  - ❑ Abundance of Desire
  - ❑ Performance Issue
  Specify ___________________
  ____
  - ❑ Pornography
  - ❑ Other __________________
- ❑ Sexual Identity Issues
  - ❑ Self
  - ❑ Partner
  - ❑ Family Member
- ❑ Self Destructive Behavior
  - ❑ Cutting
  - ❑ Eating Disorder
  - ❑ Picking (Skin, Nails, Hair)
  - ❑ Other __________________
- ❑ Relationship Issues
  - ❑ Spouse/Partner
    - ❑ Infidelity
    - ❑ Trust
    - ❑ Violence
    - ❑ Abuse
  - ❑ Parents
  - ❑ Children
  - ❑ Siblings
  - ❑ Friends
  - ❑ Co-Workers
  - ❑ Boss
  - ❑ Lack of Relationships
  - ❑ Other __________________
- ❑ Body Image Issues
  - ❑ Weight Issues
  - ❑ Obsessive Thinking re: Food/Weight
  - ❑ Binging
  - ❑ Purging
  - ❑ No Appetite
  - ❑ Too Much Appetite
- ❑ Personality Traits
  - ❑ Shy
  - ❑ Assertiveness
  - ❑ Judgmental
  - ❑ Secretive
  - ❑ Suspicion
  - ❑ Jealousy
  - ❑ Other __________________

Social/Other Information

Do you smoke? ❑ Yes ❑ No If yes, how much? ______________________________________

Do you drink alcohol? ❑ Yes ❑ No If yes, how much? ______________________________________

Do you drink caffeine products? ❑ Yes ❑ No If yes, how much? ______________________________________

Do you use other recreational drugs? ❑ Yes ❑ No If yes, how much? ______________________________________

Are there other abuse/addiction issues I should be aware of? ❑ Yes ❑ No If yes, please check any/all that apply:

❑ Alcohol ❑ Drugs: Specify ______________________ ❑ Gambling ❑ Sex ❑ Shopping

❑ Internet: Specify _______________________ ❑ Other: Specify_____________________________________

What are your current stressors? ____

____

____

Name five of your positive attributes ____

____

____

Please describe what prompted you to make this appointment ____

____

____

____

What are your goals for therapy? ____

____

____

____

Is there anything else you would like me to know? ____

____

____

____

To the best of my knowledge, the information provided in this intake is correct. I will notify you of any changes in this information.

____

Client Signature Printed Name Date

____

Signature of parent/guardian (minor) Printed Name Relationship To Client Date

____

Signature of parent/guardian (minor) Printed Name Relationship To Client Date