

New Client-Intake Form

Personal Information

Today's Date: _____ Age: _____ Gender: _____

Name: _____ Date of Birth: ____/____/____

Parent/Legal Guardian (if under 18): _____

Address: _____
Street City State Zip

Home Phone: _____ May I leave a message? Yes No
Mobile Phone: _____ May I leave a message? Yes No
Email: _____ May I leave a message? Yes No

* Please note: email is not considered a confidential form of correspondence.

Education: _____ Occupation: _____

Marital Status:

- Never Married Domestic Partnership Married
 Separated Divorced Widowed

Closest Relationships:

Name	Relationship	Age	Do they live with you?
_____	_____	_____	_____
_____	_____	_____	_____

Please describe your current living arrangement: _____

Emergency Contact: _____
Name, Relationship Phone Number
Address: _____
Street City State Zip

Referred By (if any): _____

History

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

No Yes, previous therapist/practitioner: _____

Are you currently taking any prescription medication? No Yes - If yes, please list:

Have you ever been prescribed psychiatric medication? No Yes - If yes, please list and provide dates:

Primary Care Physician: _____
Name Phone

May we send your doctor a short note, letting him/her know you've come to see us? (We do not release details other than your name for referral purposes.) No Yes

General and Mental Health Information

1. How would you rate your current physical health? (Please circle one)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:

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

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:

3. How many times per week do you generally exercise? _____

What types of exercise do you participate in? _____

4. Please list any difficulties you experience with your appetite or eating problems:

5. Are you currently experiencing overwhelming sadness, grief or depression?
 No Yes - If yes, for approximately how long? _____

6. Are you currently experiencing anxiety, panic attacks or have any phobias?
 No Yes - If yes, when did you begin experiencing this? _____

7. Are you currently experiencing chronic pain? No Yes - If yes, please describe:

8. Do you drink alcohol more than once a week? No Yes

9. How often do you engage in recreational drug use?
 Daily Weekly Monthly Infrequently Never

10. Are you currently in a romantic relationship? No Yes - If yes, for how long?

On a scale of 1-10 (with 1 being poor and 10 being exceptional), how would you rate your relationship? _____

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

Family Mental Health History

In the section below, identify if there is a family history of any of the following. If yes, please indicate the relationship to you: (i.e. mother, brother, uncle, etc.)

Mental Issue	Please Circle	Family Member(s)
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	_____
Other: _____ (Please specify)	Yes / No	_____

Additional Information

1. Are you currently employed? No Yes – If yes, what is your current employment?

Do you enjoy your work? _____

Is there anything stressful about your current work? _____

2. Do you consider yourself to be spiritual or religious? No Yes – If yes, describe your faith or belief: _____

3. How can I help? In your own words what brings you here today? _____

4. What are your two most important goals for therapy?

1. _____

2. _____

5. Is there anything else you'd like me to know? _____
