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Psychotherapy Client Intake Form

Please provide the following information and bring it with you to your first appointment. Leave blank any answers you do not feel comfortable answering. The information you provide on this form is confidential and will not be shared without your consent. If there is any other information that you would like me to know, please feel free to write it on the last page.

PERSONAL INFORMATION

Last Name: _____ First Name: _____ MI: _____

Name of Parent/Guardian (*if under 18*): _____ Relationship: _____

Date of Birth: _____ / _____ / _____ Email: _____

Phone (*check preferred*): ☐ Mobile: _____ ☐ Home: _____

May I leave a voicemail message? ☐ Yes ☐ No ☐ Only on preferred phone number

May I send a text message? ☐ Yes ☐ No ☐ Only on preferred phone number

Mailing Address: _____

MENTAL AND PHYSICAL HEALTH

1. How would you rate your current **physical** health?

   ☐ Poor ☐ Fair ☐ Good ☐ Excellent

   Comments: _____

2. Are you currently experiencing specific health issues? ☐ No ☐ Yes

   If yes, please describe: _____

3. How would you rate your current sleeping habits?

   ☐ Poor ☐ Fair ☐ Good ☐ Excellent

4. Are you currently experiencing any sleep problems? ☐ No ☐ Yes
   If yes, please describe: _____

5. How many times per week do you exercise? _____ What types of exercise do you engage in?
   _____

6. Are you currently experiencing eating or appetite problems? ☐ No ☐ Yes
   If yes, please describe: _____

7. Are you currently experiencing overwhelming grief or depression? ☐ No ☐ Yes
   If yes, please describe: _____

8. Are you currently experiencing anxiety, panic attacks, or phobias? ☐ No ☐ Yes
   If yes, please describe: _____

9. Are you currently experiencing any chronic pain? ☐ No ☐ Yes
   If yes, please describe: _____

10. Are you currently taking any psychiatric medications? ☐ No ☐ Yes
    If yes, which ones and what dosage? _____

11. Have you ever experienced any of the following? (*Please indicate with a * which ones you are currently experiencing.*)

Anxiety	☐ No	☐ Yes
Depression	☐ No	☐ Yes
Self-harming behaviors	☐ No	☐ Yes
Drug and/or alcohol abuse	☐ No	☐ Yes
Hallucinations	☐ No	☐ Yes
Eating disorder	☐ No	☐ Yes
Body image problems	☐ No	☐ Yes
Repetitive thoughts (e.g., obsessions)	☐ No	☐ Yes
Repetitive behaviors (e.g. compulsions)	☐ No	☐ Yes
Panic attacks	☐ No	☐ Yes
Unexplained losses of time	☐ No	☐ Yes
Mood swings	☐ No	☐ Yes
Mania	☐ No	☐ Yes

12. Have you experienced any recent life changes or major events that are having an impact on your physical or mental health? ☐ No ☐ Yes If yes, please describe: _____

_____

_____

_____

LIFESTYLE & EMPLOYMENT

13. Please describe your current average alcohol intake:
☐ I don't drink alcohol **OR** I drink about _____ drinks per ☐ day ☐ week ☐ month

14. How often do you use recreational drugs?
☐ Never ☐ Infrequently ☐ Monthly ☐ Weekly ☐ Daily
If yes, please describe: _____

15. How would you describe your romantic status?
☐ Single ☐ In a relationship ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

16. If you are currently in a relationship, for how long? _____

17. If you are currently in a relationship, how would you describe the quality of your relationship?

_____

18. Do you have any children? ☐ No ☐ Yes
If yes, how many and what ages? _____
Do they live with you? ☐ No ☐ Yes ☐ Other (specify): _____

19. Are you currently employed? ☐ No ☐ Yes
If yes, what is your occupation? _____

20. If you are currently employed, how satisfied are you with your work?
☐ Very unsatisfied ☐ Unsatisfied ☐ Neutral ☐ Somewhat satisfied ☐ Very satisfied

21. If you are currently employed, how stressful is your job?
☐ Very stressful ☐ Stressful ☐ Neutral ☐ Not very stressful ☐ No stress

22. Do you consider yourself to be a religious or spiritual person? ☐ No ☐ Yes

If yes, please describe: _____

23. Have you ever been in therapy before? ☐ No ☐ Yes

If yes, with who and when? _____

24. What would you like to accomplish in therapy? _____

_____

_____

_____

FAMILY MENTAL HEALTH HISTORY

Please identify any family mental health history of which you are aware. If you respond yes, please identify the relationship of that family member to you (e.g., father, sister, etc.)

			Relationship
Alcohol / Substance Abuse	☐ No	☐ Yes	_____
Anxiety.....	☐ No	☐ Yes	_____
Depression	☐ No	☐ Yes	_____
Domestic Abuse	☐ No	☐ Yes	_____
Eating Disorders.....	☐ No	☐ Yes	_____
Obesity	☐ No	☐ Yes	_____
Obsessive Compulsive Behavior.....	☐ No	☐ Yes	_____
Schizophrenia.....	☐ No	☐ Yes	_____
Suicide Attempts	☐ No	☐ Yes	_____

ADDITIONAL INFORMATION

If there is any other information you would like to share, please feel free to include it here:

_____

_____

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