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CLIENT INTAKE FORM Date:_____

Name:_____ Date of Birth:_____

Address:_____

City:_____ State:_____ ZIP:_____

Phone (circle best number to call); Check if ok to leave messages or text:
□ Home:_____ □ Cell:_____ □ Text:_____ (Initial) Note: texting/phone calls m
not be considered confidential

Email:_____ May I e-mail you? □ Yes □ No (Initial)_____
*Please note: Email correspondence may not be considered a confidential medium of communication.

Emergency Contact:_____ Phone Number:_____
Relation to you:_____

Marital Status (please circle):
Single/ Married/ **Divorced/** Separated/ **Widowed/** Domestic Partnership
Number of previous marriages, if any:_____
Please list any children/age: _____
_____

Insurance
Name of medical insurance plan, if any:_____
Insurance Number:_____
Insurance Group: _____

Primary Insured Information Name of Primary
Insured:_____ Primary Insured person's Date of
Birth: _____ Primary Insured Phone: _____
Address:_____ City:
_____ State:_____ ZIP:_____

Employment information

Currently employed? □ Yes □ No Employer's Name:_____
Job title:_____ Years at this job:_____

Education information Highest level of education completed:_____

General Health
Last complete physical exam?_____

Do you have a primary care physician?_____

Do you currently take prescription medication? _____
_____

Mental Health Information

1. What brings you to therapy? Be as specific as you can and rate if the problem is mild, moder-ate or severe.
_____
_____
_____
_____
_____

2. Substance Use: please circle (present = in the past 2 weeks):

	Present	Past		Present	Past		Present	Past
Tobacco	Y N	Y N	Alcohol	Y N	Y N	Marijuana	Y N	Y N
Caffeine	Y N	Y N	Amphetamines	Y N	Y N	LSD	Y N	Y N
PCP	Y N	Y N	Opiates	Y N	Y N	Mushrooms	Y N	Y N
Sedatives	Y N	Y N	Cocaine	Y N	Y N			

3. In the past 3 months have you experienced significant symptoms of (please circle):

Aggression**/** Crying/ Fear**/** Irritability/ Self-destructive relationships
Anger/ Denial/ Flashbacks/ Memory Problems**/** Self-harm behaviors
Anxiety/ Depression/ Guilt/ Nightmares/ Sexual acting out
Apathy/ Difficulty concentrating**/** Harm or threat to others/ Obsessive behavior/
Somatic (Body) Complains/ Avoidance/ Disordered eating pattern/s Hyperactivity/ Panic/
Behavior problems/ Dissociation/ Hyperarousal/ Phobias/ Compulsive behavior/
Emotional numbing/ Insomnia/sleep problems/ Self-blame/ Other:

4. Have you ever tried to hurt yourself? □ Yes □ No If yes, when?_____
Describe what happened_____
_____

5. Have you ever tried to hurt someone else? □ Yes □ No If yes, when?_____
Describe what happened_____
_____

6. Have you ever been hospitalized for psychiatric reasons? ? □ Yes □ No

If yes, when/ what happened?_____
_____

7. Are you currently in a romantic relationship? □ Yes □ No If yes, for how long? _____
How is the quality of your relationship? _____
_____
_____
_____

8. In general, how is your relationship with your children/step-children (if applicable)?_____
_____
_____

9. In general, how is your relationship with your parents and siblings (if applicable)?
_____
_____
_____

10. Have you experienced any recent significant life changes or stressful events?
_____
_____
_____

Family Mental Health History
In the section below, identify if there is a family history of any of the following:
Alcohol/Substance Abuse: _____
Anxiety: _____
Depression: _____
Domestic Violence: _____
Eating Disorders: _____
Obesity: _____
Obsessive Compulsive Behavior:_____
Schizophrenia: _____
Suicide Attempts: _____

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

12. What gives you the most pleasure or joy in your life?
_____
_____
_____

13. What are your main fears and/or concerns that bring you in to therapy/counseling today?
_____
_____
_____

14. What do you expect to gain from therapy/counseling?
_____
_____
_____

Client's Name:_____

Client's DOB:_____

Intake Date:_____

Treatment Plan

Areas of Impairment

1).

2).

3).

Treatment Objectives

1).

2).

3).

DSM V Diagnosis: 1)_____ 2)_____ 3)_____

Client's Signature:_____ Date:_____

Parent/Legal Guardian's Signature:_____ Date:_____