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**** CONFIDENTIAL Client Intake Form ****
Please bring this form completed to your first appointment.

Name: Prefer to Be Called: _____ **Today's Date:** _____
Last _____ First _____ MI _____
Maiden/Other _____ Date of Birth _____ Age _____

Address & Phone:

Street _____ City/State _____ Zip code _____
Who lives there with you (& their relationships to you)? _____
Email Address _____

Permanent Mailing Address (if different from above):

Street _____ City/State _____ Zip code _____
Telephone #'s: Home _____ Work _____ Cell _____

Which number(s) may I call & leave a message on (circle)? (Home) (Work) (Cell)

Emergency Contacts:

Name _____ Phone # _____ Relationship _____
Name _____ Phone # _____ Relationship _____
Name _____ Phone # _____ Relationship _____

Demographics (Circle all that apply, all are OPTIONAL.)

<u>Ethnic Group You Identify As</u>	<u>Relationship Status</u>	<u>Religious/Spiritual Affiliation(s)</u>
American Indian/Alaskan Native	Single	_____
Asian	Partnered	_____
Black/African-American	Separated	
Native Hawaiian/Pacific Islands	Widowed	
White/Caucasian	Other _____	
Latina/Latino		
Middle-Eastern	Do you have children? __No __Yes	
Multi-Ethnic	If yes, how many, ages, where do they live?	
Other/Details: _____		

Gender

Female
Male
Transsexual/Transgender
Other _____

Preferred Gender Pronoun: _____

Sexual Orientation

Bisexual
Gay/Lesbian
Heterosexual
Uncertain
Queer

Current Employment Status

Employed – Full Time
Employed – Part Time
Not in Labor Force
Student – Full Time
Student – Part Time

Family History

Briefly, describe your family of origin: _____

What was it like growing up in your family? _____

List any psychiatric (*anxiety, depression, bipolar, schizophrenia, substance abuse, etc.*) or medical illnesses that you/your family/relatives have experienced.

(if known) Birth History

Parent's age at time of your birth: *Mother* ____ *Father* ____

Was this a planned pregnancy? Yes No *Don't Know*

Any tobacco, drug or alcohol use during pregnancy? Yes No *Don't Know*

Any complications during pregnancy, labor or delivery? Yes No *Don't Know*

Did your mother experience postpartum depression following birth? Yes No *Don't Know*

Anything else you know/want to share of your birth history ...

Medical History

Allergies? _____ Past prescribed medications _____

Childhood illnesses/surgeries? _____

Previous hospitalizations? _____

Anything else

What questions or concerns do you have?

Anything else you would like me to know in working together? _____

Referred by: _____

I sometimes thank referrals in a way that is general, non-identifying. Would that be okay with you? (yes) or (no, thanks)

SYMPTOM CONCERNS:

Please circle appropriate responses – Feel free to write in other responses

*Star appropriate responses (*) that you would like to address in counseling*

Sleep: No problems Not enough Trouble getting to sleep Nightmares
Too much sleep Trouble getting up Tired upon waking up

Appetite: No problems Decreased Increased

Exercise: None Infrequently Often Frequency: _____ x per month / week

Energy: Normal Increased Low Up and down

Interest in sex: Normal Increased Low

Concentration: Normal Difficult Poor Terrible

Memory: Good Some difficulty Poor

Mood (Generally):

Thoughts: racing worries fears repetitive invincible detached paranoid

Reaction to Touch, Sounds, Lights, Tastes, Smells

Depressed or sad: All the time Most days Some days Not at all

Social (friends, support):

Suicidal thoughts: All the time Most days Some days Not at all

Past suicidal attempts: No Yes

Anxiety: Panic attacks All the time Most days Some days Not at all

Anger / Irritation: All the time Most days Some days Not at all

Are you religious or spiritual? No Yes; If yes, please give details:

Have you ever suffered from any type of eating disorder? Yes No

Have you ever been charged with a crime, arrested or convicted? Yes No

Have you ever struggled with substance use/abuse? Yes No

Do you have any work-related problems or difficulties in school? Yes No

Do you have a history of trauma (i.e. abuse, neglect, natural or other disaster)? Yes No

On a scale of 0-10, how important is therapy to you right now? (0-not important; 10-very important)? _____