



Returning Client Intake Form

Client Information

Name _____ Date of Birth _____

Address _____

Phone _____ Email _____

Emergency Contacts

Name _____ Name _____

Relationship _____ Relationship _____

Phone _____ Phone _____

Mental/Physical Health

What brings you back to therapy? _____

Any changes in your psychiatric medications? If yes, what medications, dosage, and frequency?

Any changes in your physical health or new medications?

Life Updates

Who do you live at home with now? _____

Relationship Updates? _____



Work or Education Updates? _____

Current Symptoms (circle all that apply)

Sad/depressed mood	Nausea/abdominal distress	Impulsive
Difficulty sleeping	Indecisiveness/slowed thinking	Dramatic mood swings
Fear of social situations	Headaches	Amnesia
Feelings of anxiety	Rapid weight change	Increased energy
Feeling on edge	Feeling dissociated	Feelings of numbness
Insomnia or hard to sleep	Weight up/down	Feeling elated
Panic attacks	Menstrual problems/changes	Nightmares
Fun activities no longer fun	Crying spells	Racing thoughts
Trembling/shakiness	Suicidal thoughts	Overspending
Restlessness	Sexual problems	Bizarre experiences
Feelings of guilt	Self-harm/cutting	Unsafe sexual activities
Irritability	Unexplained pain	Hallucinations
Low self esteem	Tendency to isolate	Decreased need for sleep
Shortness of breath	Fear of being alone	Intrusive bothersome thoughts
Feelings of helplessness	Difficulty focusing	Repetitive compulsions
Heart palpitations/chest pain	Difficulty with relationships	Alcohol abuse/dependency
Feelings of hopelessness	Difficulty in organizing tasks	Drug abuse/dependency
Sweats	Forgetfulness	Difficulty with control of anger
Fatigue/low energy	Problems at work/home	Homicidal or violent thoughts
Dizziness	Distractibility	Family problems
Decreased concentration	Purging food	Legal problems

Anything else you'd like me to know? _____

Signature

Date

Print Name