Intake Form

Client Information

Name _____ Date of Birth_____

Preferred Name/Nickname_____

Gender/Sex _____ Sexual Orientation _____

Address _____

_____

Phone _____ Email _____

Emergency Contacts

Name _____ Name _____

Relationship _____ Relationship _____

Phone _____ Phone _____

Mental Health

What brings you into therapy? _____

_____

_____

Do you have any mental health diagnoses? _____

Have you previously sought out mental health assistance? _____If so, who and where?

_____

Are you on any psychiatric medications? If yes, what medications, dosage, and frequency?

_____

_____

Symptoms (circle all that apply)

Sad/depressed mood
Difficulty sleeping
Fear of social situations
Feelings of anxiety
Feeling on edge
Insomnia or hard to sleep
Panic attacks
Fun activities no longer fun
Trembling/shakiness
Restlessness
Feelings of guilt
Irritability
Low self esteem
Shortness of breath
Feelings of helplessness
Heart palpitations/chest pain
Feelings of hopelessness
Sweats
Fatigue/low energy
Dizziness
Decreased concentration

Nausea/abdominal distress
Indecisiveness/slowed thinking
Headaches
Rapid weight change
Feeling dissociated
Weight up/down
Menstrual problems/changes
Crying spells
Suicidal thoughts
Sexual problems
Self-harm/cutting
Unexplained pain
Tendency to isolate
Fear of being alone
Difficulty focusing
Difficulty with relationships
Difficulty in organizing tasks
Forgetfulness
Problems at work/home
Distractibility
Purging food

Impulsive
Dramatic mood swings
Amnesia
Increased energy
Feelings of numbness
Feeling elated
Nightmares
Racing thoughts
Overspending
Bizarre experiences
Unsafe sexual activities
Hallucinations
Decreased need for sleep
Intrusive bothersome thoughts
Repetitive compulsions
Alcohol abuse/dependency
Drug abuse/dependency
Difficulty with control of anger
Homicidal or violent thoughts
Family problems
Legal problems

General Health

How is your physical health? _____

Are you diagnosed with any medical conditions I should be aware of? _____

_____

Are you taking any medications for health? _____ If so, what? _____

_____

Any over-the-counter medications/supplements/herbs? _____

Do you exercise? How? _____

How is your appetite/diet? _____

Substance or Drug Use? _____ If so, what and how often? _____

Do you drink alcohol? _____ If so, how often? _____

Do you use nicotine? _____ If so, how much? _____

Family History

How would you describe your relationship with your family? _____

_____

_____

Please indicate any of the following:

	Yes	No	Family members
Anxiety			
Depression/Bipolar			
Eating Disorders			
Schizophrenia			
Alcoholism			
Drug Abuse			
Suicide/suicide attempts			
Incarceration			
Domestic Violence			
Deceased			
Other: _____			

Home Life

Who do you live at home with? _____

Do you feel safe at home? _____

Are you in a relationship? _____ If so, tell me about your relationship and/or history.

_____

_____

Employment/School Status

Are you currently working? _____ If so, where? _____

What is your occupation? _____

Are you currently in school? _____ If so, where? _____

What are you studying? _____

What is your highest level of education? _____

Tell me about your work/school. Any problems or concerns? _____

_____

Who are your supports? _____

_____

How do you normally cope with your problems? _____

_____

Do you have a religious or spiritual practice? _____

_____

Anything else you'd like me to know? _____

_____

Appointment Availability (check all availability)

	Monday	Tuesday	Wednesday	Thursday	Friday
9am-10am					
10am-11am					
11am-12pm					
12pm-1pm					
1pm-2pm					[redacted]
2pm-3pm					
3pm-4pm					

How did you hear about me? _____

_____ _____

Signature Date

_____

Print Name

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