

## CLIENT INTAKE FORM

*Please provide the following information for our records. Leave blank any question you would rather not answer, or would prefer to discuss with your therapist. Information you provide here is held to the same standards of confidentiality as our therapy.*

### TREATMENT HISTORY

Are you currently receiving psychiatric services, professional counseling or psychotherapy elsewhere?  yes  no

Have you had previous psychotherapy?

no

yes, with (previous therapist's name) \_\_\_\_\_

Are you currently taking prescribed psychiatric medication (antidepressants or others)?  yes  no

If yes, please list: \_\_\_\_\_

Prescribed by: \_\_\_\_\_

### HEALTH AND SOCIAL INFORMATION

Do you currently have a primary physician?  yes  no

If yes, who is it? \_\_\_\_\_

Are you currently seeing more than one medical health specialist?  yes  no

If yes, please list: \_\_\_\_\_

When was your last physical? \_\_\_\_\_

Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.): \_\_\_\_\_

---

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions Code, Civil Code and HIPPA Privacy Standards. Duplication of this information for further disclosure is prohibited without prior written authorization of the client/ authorized representative to who it pertains unless other permitted by law.

Are you currently on medication to manage a physical health concern? If yes, please list: \_\_\_\_\_

Are you having any problems with your sleep habits? ( ) yes ( ) no

If yes, check where applicable:

( ) Sleeping too little ( ) Sleeping too much ( ) Poor quality sleep  
( ) Disturbing dreams ( ) other \_\_\_\_\_

How many times per week do you exercise? \_\_\_\_\_

Approximately how long each time? \_\_\_\_\_

Are you having any difficulty with appetite or eating habits? ( ) no ( ) yes

If yes, check where applicable: ( ) Eating less ( ) Eating more ( ) Bingeing  
( ) Restricting

Have you experienced significant weight change in the last 2 months? ( ) no ( ) yes

Do you regularly use alcohol? ( ) no ( ) yes

In a typical month, how often do you have 4 or more drinks in a 24 hour period?

\_\_\_\_\_

How often do you engage recreational drug use? ( ) daily ( ) weekly ( ) monthly  
( ) rarely ( ) never

Do you smoke cigarettes or use other tobacco products? ( ) yes ( ) no

Have you had suicidal thoughts recently?

( ) frequently ( ) sometimes ( ) rarely ( ) never

Have you had them in the past?

( ) frequently ( ) sometimes ( ) rarely ( ) never

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions Code, Civil Code and HIPPA Privacy Standards. Duplication of this information for further disclosure is prohibited without prior written authorization of the client/ authorized representative to who it pertains unless other permitted by law.

Are you currently in a romantic relationship? ( ) no ( ) yes

If yes, how long have you been in this relationship? \_\_\_\_\_

On a scale of 1-10 (10 being the highest quality), how would you rate your current relationship? \_\_\_\_\_

In the last year, have you experienced any significant life changes or stressors? If yes, please explain: \_\_\_\_\_

Have you ever experienced any of the following?

|   |                             |
|---|-----------------------------|
| Extreme depressed mood                                      | Yes / No                    |
| Dramatic mood swings  | Yes / No                    |
| Rapid speech  | Yes / No                    |
| Extreme anxiety   | Yes / No                    |
| Panic attacks   | Yes / No                    |
| Phobias   | Yes / No                    |
| Sleep disturbances  | Yes / No                    |
| Hallucinations  | Yes / No                    |
| Unexplained losses of time                                  | Yes / No                    |
| Unexplained memory lapses                                   | Yes / No                    |
| Alcohol/substance abuse                                     | Yes / No                    |
| Frequent body complaints                                    | Yes / No                    |
| Eating disorder   | Yes / No                    |
| Body image problems   | Yes / No                    |
| Repetitive thoughts (e.g. obsessions)                       | Yes / No                    |
| Repetitive behaviors (e.g. frequent checking, hand washing) | Yes / No                    |
| Homicidal thoughts  | Yes / No                    |
| Suicidal attempts   | Yes / No      If yes, when? |

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions Code, Civil Code and HIPPA Privacy Standards. Duplication of this information for further disclosure is prohibited without prior written authorization of the client/ authorized representative to who it pertains unless other permitted by law.

**OCCUPATIONAL INFORMATION**

Are you currently employed? ( ) no ( ) yes

If yes, who is your currently employer/position? \_\_\_\_\_

If yes, are you happy with your current position? \_\_\_\_\_

Please list any work-related stressors, if any \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**RELIGIOUS/SPIRITUAL INFORMATION**

Do you consider yourself to be religious? ( ) no ( ) yes

If yes, what is your faith? \_\_\_\_\_

If no, do you consider yourself to be spiritual? ( ) no ( ) yes

**FAMILY MENTAL HEALTH HISTORY**

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (circle any that apply and list family member, e.g. sibling parent, uncle, etc.)

| <b>Difficulty</b>       | <b>Yes / No</b> | <b>Family member</b> |
|-------------------------|-----------------|----------------------|
| Depression              | Yes / No        |                      |
| Bipolar disorder        | Yes / No        |                      |
| Anxiety disorder        | Yes / No        |                      |
| Panic attacks           | Yes / No        |                      |
| Schizophrenia           | Yes / No        |                      |
| Alcohol/substance abuse | Yes / No        |                      |
| Eating disorders        | Yes / No        |                      |
| Learning disabilities   | Yes / No        |                      |
| Trauma history          | Yes / No        |                      |
| Suicide attempts        | Yes / No        |                      |
| Chronic illness         | Yes / No        |                      |
|                         |                 |                      |
|                         |                 |                      |
|                         |                 |                      |

**OTHER INFORMATION**

What do you consider to be your strengths? \_\_\_\_\_

---

---

What do you like most about yourself? \_\_\_\_\_

---

---

What are effective coping strategies that you have learned? \_\_\_\_\_

---

---

What are your goals for therapy?

---

---

---

---

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions Code, Civil Code and HIPPA Privacy Standards. Duplication of this information for further disclosure is prohibited without prior written authorization of the client/ authorized representative to who it pertains unless other permitted by law.

