**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.***

**PERSONAL INFORMATION:**

Client Name: Click or tap here to enter text.

Date of Birth: Click or tap here to enter text. Age: Click or tap here to enter text.

Street Address:Click or tap here to enter text.

City/State: Click or tap here to enter text.

Zip Code: Click or tap here to enter text.

Sex: Female Male Transgender M to F Transgender F to M

Religious Affiliation (if any): Click or tap here to enter text.

Home Phone: Click or tap here to enter text.

Is it okay to leave a message? Yes No 

Work Phone:Click or tap here to enter text.

Is it okay to leave a message? Yes No 

Cell Phone: \_Click or tap here to enter text.

Is it okay to leave a message? Yes No 

Email Address:Click or tap here to enter text.

May we email you? Yes No 

In an emergency, who do we call?

Contact Name: Click or tap here to enter text.

Contact Phone: Click or tap here to enter text.

Employer: Click or tap here to enter text.

Length of Employment: Click or tap here to enter text.

Occupation: \_Click or tap here to enter text.

Highest Level of Education Completed: Click or tap here to enter text.

**INSURANCE INFORMATION**

Name of Insurance Company: \_Click or tap here to enter text.

Insurance Co. Phone # (Mental Health): Click or tap here to enter text.

Policy Owner’s Name: Click or tap here to enter text.

Policy Owner’s Date of Birth: Click or tap here to enter text.

Policy Owner’s SS#:Click or tap here to enter text.

Insurance ID #: \_Click or tap here to enter text.

Policy or Group#: \_Click or tap here to enter text.

Policy Owner’s Address (only if different from above): Click or tap here to enter text.

Please be prepared to provide your insurance card so that we may make a copy.

**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)\_Click or tap here to enter text.

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

If yes, please list: Click or tap here to enter text.

Prescribed by: Click or tap here to enter text.

**HEALTH AND SOCIAL INFORMATION**

Do you currently have a primary physician?  yes  no

If yes, who is it? Click or tap here to enter text.

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

If yes, please list: Click or tap here to enter text.

When was your last physical? Click or tap here to enter text.

Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.: Click or tap here to enter text.

Are you currently on medication to manage a physical health concern? If yes, please list: Click or tap here to enter text.

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? Click or tap here to enter text.

Approximately how long each time? Click or tap here to enter text.

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?

Click or tap here to enter text.

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

Are you currently in a romantic relationship? no yes

If yes, how long have you been in this relationship? Click or tap here to enter text.

On a scale of 1-10 (10 being the highest quality), how would you rate your current relationship? Click or tap here to enter text.

In the last year, have you experienced any significant life changes or stressors? If yes, please explain: Click or tap here to enter text.

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? |

**OCCUPATIONAL INFORMATION**

Are you currently employed? no yes

If yes, who is your currently employer/position? Click or tap here to enter text.

If yes, are you happy with your current position? Click or tap here to enter text.

Please list any work-related stressors, if any Click or tap here to enter text.

**RELIGIOUS/SPIRITUAL INFORMATION**

Do you consider yourself to be religious? no yes

If yes, what is your faith? Click or tap here to enter text.

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? (check any that apply and list family member, e.g. sibling parent, uncle, etc.)

|  |  |  |
| --- | --- | --- |
| **Difficulty** | **Yes / No** | **Family member** |
| 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? Click or tap here to enter text.

What do you like most about yourself? Click or tap here to enter text.

What are effective coping strategies that you have learned? Click or tap here to enter text.

What are your goals for therapy? Click or tap here to enter text.