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Client Intake Form

Basic Info

First Name _____ Last Name _____
Address _____
City _____ State/Province _____
Zip/Postal Code _____ Country _____
Mobile Cell Phone _____ Work Phone _____
Home Phone _____
Email Address _____ Email Address (2) _____
Date of Birth ____ / _____ / _____ City/State/Country of Birth _____

Circle the gender you best identify with

Female Male Transgender Male Transgender Female Non-Binary Other

Family & Partnerships

Circle your marital status

Single Married Divorced Separated Domestic Partner Widow/er Engaged

Name of Partner or Spouse (if married) _____

How long partnered? _____

On a scale of 1-10, How would you rate your relationship? 1=Poor 10=Excellent

1 2 3 4 5 6 7 8 9 10

Were you previously married or divorced? _____
If so – how many times? _____
If yes – how long was your first marriage? _____
If yes, how long was your 2nd/3rd marriage? _____

Do you have children? If yes, how many? Please list their ages.

_____
_____

Who do you live with? Circle all that apply.

Self Roommate Partner Spouse Children Other/Pets

Is your mother deceased? If so, what year?

_____

Is your father deceased? If so, what year?

_____

Do you have any brothers? If so, how many?

_____

Do you have any sisters? If so, how many?

_____

What number in rank are you? (eg: Oldest, Middle, Youngest etc.)

_____

Any deceased siblings?

_____

Education & Work

Highest Grade/Degree _____

Current Employment Status/ Position _____

Do you enjoy your work?

_____
_____
_____
_____
_____

General Health & Mental Health Information

Have you previously received any type of mental health services?
Circle all that apply (eg: psychotherapy, psychiatric services, etc)

Individual Couples Family Group Psychiatric Imago Other

If yes, list the previous therapist(s)/practitioner(s) name(s)

Any prescription medications?
Please list each medication, and the reason.

How would you rate your current sleeping habits?

Poor Unsatisfactory Satisfactory Good Very Good

Please list any specific sleep problems you are currently experiencing.

If you exercise, what activities and how often?

Please list any difficulties you experience with your appetite or eating patterns.

Are you currently experiencing overwhelming sadness, grief, or depression? _____

If yes, for approximately how long? Provide a brief summary.

_____
_____
_____
_____

Are you currently experiencing anxiety, panic attacks, or have any phobias? _____

If yes, when (and what) did you begin experiencing this?

_____
_____
_____
_____

Are you currently experiencing any chronic pain? _____

If yes, please describe.

_____
_____
_____
_____

What is the frequency of your alcohol consumption?

Never Rarely Often Too Often Sometimes people are concerned about my alcohol usage Other

If other, please describe. _____

How often do you engage in recreational drug use?

Never Rarely Often Too Often Sometimes people are concerned about my drug use Other

If other, please describe. _____

What significant life changes or stressful events have you experienced recently?

_____
_____
_____
_____

Do you consider yourself to be spiritual or religious? If so, Please describe your faith or belief

Family Mental Health History

In the section below, identify if there is a family history of any of the following.
If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc)
Circle all that apply.

Alcoholism Substance Abuse Depression Anxiety Domestic Violence Eating Disorders

Obesity Obsessive Compulsive Behavior Schizophrenia Bi-Polar/Manic Depression Suicide Attempts

Please indicate the family member's health challenge & relationship to you.

If any area circled "yes" please provide any details that are important or use for me to know.

What do you consider to be some of your strengths?

What do you consider to be some of your challenges?

_____
_____
_____
_____

What would you like to accomplish out of your time in therapy?

_____
_____
_____
_____

Indicate the kind of therapy you are requesting.
Circle all that apply.

Individual Couples Family Group Imago

How or by whom were you referred?

__ Personal reference
__ Professional reference
__ A publication where I was a contributing editor
__ Google
__ Yelp
__ Other _____

If personally referred, who? _____

If professionally referred, who? _____

Thank you for sharing with me & completing this intake form.
I look forward to working with you.

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