CLIENT INTAKE FORM

Please print out this form and bring it to your first session.

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Date of first appointment: _____

Please take your time in providing the following information. The questions are designed to help me begin to understand you so that our time together can be as productive as possible. All information provided is confidential.

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Contact Information:

Your name: _____Today's date: _____
Birth Date: _____ /_____ /_____ Age: _____ Gender: _____

Home street address:

_____

City: _____ State: _____ Zip: _____

Home Phone: ( ) - Cell Phone: ( ) - Work Phone: ( ) -

E-mail:

_____

Best time and way to reach you

_____

If some kind of emergency arises and I need to reach someone close to you, whom should I call?

Name:_____
Phone:
_____Relationship:_____

History:

1. Are you currently employed/attend school? ❑ No ❑ Yes

Who is your current employer/school?_____

What is your position?_____

What is your level of education?_____

2. What is your romantic relationship status? ❑ Married ❑ Separated ❑ Divorced ❑ Single ❑ Engaged ❑ Remarried ❑ Widowed ❑ Partnered/Significant Other ❑ Cohabiting ❑ Beginning New Relationship

3. On a scale of 1-10, how would you rate the quality of your current relationship? _____

4. What are some of the challenges you are facing in your current relationship?

_____

_____

5. Have you had previous therapy before? ❑ No ❑ Yes

If so, what did you find helpful?

_____

Unhelpful?

_____

6. Are you on any medications? ❑ No ❑ Yes If yes, what?

_____

7. Any stressors in the past 12 months?

_____

_____

8. What are your goals for therapy?

_____

_____

Main Concern: Please briefly describe the issue(s) that brought you to counseling, and what concerns you the most right now:

_____

_____

Please check any of the concerns that apply or have applied to you:

- Depressed mood ___
- Anxiety or panic attacks___
- Mood swings___
- Sleep disturbances___
- Grief and loss___
- Crying spells___
- Obsessive thoughts/behaviors___
- Irritability___
- Confusion___
- Phobias/fears___
- Weight loss/gain___
- Body image concerns___
- Recent heath issues___
- Past physical/sexual abuse____
- Alcohol/substance use____
- Concerns with parenting___
- Work related concerns____
- Problems with school____
- Money management___
- Trouble with memory___
- Difficulty with motivation___
- Impulsivity___
- Restlessness___
- Easily distracted____
- Difficulty completing tasks____
- Problems with time management___
- Perfectionistic thinking___
- Problems with anger__
- Relationship problems___
- Unwanted habits____
- Self harm (cutting, burning)___
- Suicidal thoughts (past/present)___
- Sexual concerns___
- Other (specify)_____

I appreciate you taking the time to fill out this form. Thank you!