Intake Information

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Demographic Information

Today's Date: _____

Full Name: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Cell Phone: _____ May I leave a message? Yes ☐ No ☐

Email Address: _____

Birth Date: _____ Age:_____ Gender:_____

Marital Status: ☐ Never Married ☐ Domestic Partnership ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Spouse's Name: _____

Duration of Marriage: _____ Previous Marriages? Yes ☐ No ☐

Education Level: _____ Degrees Held: _____

Occupation: _____ Employer: _____

Referral Source: _____ May I thank them? _____

Emergency Contact Information

Full Name: _____
Last *First* *M.I.*

Primary Phone: _____ Alternate Phone: _____

Relationship: _____

Mental Health Information

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

_____
_____
_____
_____
_____
_____

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

_____
_____
_____
_____
_____

Are you currently experiencing, or have you experienced any of the following in the past 6 months:

___ Excessive worry
___ Irritability
___ Poor concentration
___ Change in sleep
___ Depressed mood
___ Sexual problems
___ Confusion
___ Health problems
___ Restlessness
___ Nightmares
___ Tension
___ Intrusive thoughts
___ Stress
___ Change in appetite
___ Loneliness
___ Headaches
___ Fatigue
___ Nervousness
___ Excessive guilt
___ Diminished self-esteem
___ Fears
___ Weight loss or gain
___ Decreased self-confidence
___ Hopelessness
___ Indecisiveness

Do you engage in self-injurious behavior?	Yes	No	Most recent:_____
Have you ever attempted suicide?	Yes	No	Date(s): _____
Are you currently having suicidal thoughts?	Yes	No	

Previous mental health treatment (list treating practitioner, dates, and reason for treatment):

_____
_____
_____
_____

Are you taking any medications (list):

_____
_____
_____
_____

Prescribing physician:

_____

Mental Health Information (continued)

How often do you use alcohol? Special Occasions ___ Monthly ___ x per month ___
Weekly ___ x per week ___ Daily ___

How many drinks do you have? _____

Other substances you use and how often? _____
_____

Family History

Is there any history of mental illness, suicide attempts, or substance abuse by parents, siblings or close relatives?

	Mood Disorder (depression, bipolar)	Anxiety	Suicide Attempts	Substance Abuse	Schizophrenia	Other
Father						
Mother						
Siblings						
Close Relative						

Additional Information

How would you rate your current physical health?

□ Poor □ Unsatisfactory □ Satisfactory □ Good □ Very Good

Please list any specific health problems you are currently experiencing:
_____
_____
_____

How would you rate your current sleeping habits?

□ Poor □ Unsatisfactory □ Satisfactory □ Good □ Very Good

Please list any sleep problems you are currently experiencing:
_____
_____
_____

How many times per week do you generally exercise? _____

What types of exercise do you participate in?
_____
_____
_____

Additional Information (continued)

If you are currently employed, do you enjoy your work? Is there anything stressful about your current work?

_____
_____
_____
_____

Do you consider yourself spiritual or religious? Yes □ No □

If yes, describe your faith or belief:

_____
_____
_____
_____

If you are in a romantic relationship, on a scale of 1 – 10 (10 being best), how would you rate your relationship? _____

Please list any children/age(s):

_____
_____
_____

Is there anything else you think would be important for me to know?

_____
_____
_____
_____
_____
_____
_____

_____ _____

Client Name (print) Client Signature Date