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Client Intake Information Form

You may fill in this form prior to your first scheduled psychotherapy session and bring with you to your appointment.

Today's Date

How would you prefer to be addressed?

Referred by:

May Dr. Sells contact this referral source to thank them for the referral? ◯ Yes ◯ No

If yes, please provide contact information for this person/agency:

Personal Data

Legal Name

Date of Birth

Address

Age

City State Zip Code

Marital Status

Email

Primary Phone Number

This phone is a:

Can Dr. Sells leave a message? ◯ Yes ◯ No

Alternate Phone Number

This phone is a:

Can Dr. Sells leave a message? ◯ Yes ◯ No

Person to be contacted in case of emergency

Emergency Contact Phone

Relationship of emergency contact to you

Address

City State Zip Code

What is your intimate relationship status?: (check as many as apply)

- ☐ dating (How long? ___________)
- ☐ in committed relationship (How long? _____________)
- ☐ domestic partnership (How long? ___________)
- ☐ married (How long? _____________) (# of previous marriages:_____)
- ☐ not dating & single (How long? ___________)
- ☐ divorced (How long? ____________) (# of previous divorces: _____)

List below the people living in the same household as you. If you reside alone, just skip over to the next area.

First & Last Name	Relationship to You	Age	Occupation

Medical History

Primary Physician

Name of Group

Address

City State Zip Code

Please list below any chronic medical conditions or medical concerns you may have.

Please list below the name(s) and dosage of ANY prescribed medications you are currently taking.

Have you ever been psychiatrically hospitalized? ◯ Yes ◯ No

If yes, when and where?

Have you ever been in any kind of counseling or psychotherapy before? ◯ Yes ◯ No

If yes, how many times have you tried a new therapy experience?

Educational & Occupational History

Highest Level of Education Attained

Are you currently pursuing educational classes? ◯ Yes ◯ No

List below your educational history, starting with high school first.

School or University	City/State	Dates Attended	Major	Degree Earned/ Expected

List below your employment history, starting from most recent backward.

Job Title	Employer Name/City	Dates	Gross Earnings per Year

Family & Social Data

Father's First Name

Father's Date of Birth

Is father living? ◯ Yes ◯ No

If no, date deceased:

How would you describe your relationship with ***father***? Please mark all that apply below.

☐ Abusive ☐ Affectionate ☐ Argumentative
☐ Close ☐ Distant ☐ Flexible
☐ Inspiring ☐ Loving ☐ Meaningful
☐ Satisfying ☐ Rigid ☐ Roller Coaster
☐ Too Close ☐ Superficial ☐ Supportive
☐ Non-existant ☐ Troubled ☐ Unsatisfying

Mother's First Name

Mother's Date of Birth

Is mother living? ◯ Yes ◯ No

If no, date deceased:

How would you describe your relationship with ***mother***? Please mark all that apply below.

☐ Abusive ☐ Affectionate ☐ Argumentative
☐ Close ☐ Distant ☐ Flexible
☐ Inspiring ☐ Loving ☐ Meaningful
☐ Non-existant ☐ Rigid ☐ Roller Coaster
☐ Satisfying ☐ Superficial ☐ Supportive
☐ Too Close ☐ Troubled ☐ Unsatisfying

Family & Social Data Con't

Did mother and father live in the family home during your childhood? ____________________

If not, how old were you when they separated? ___________________________

If you have brothers and/or sisters, please list the information below regarding them.

First Name	Age	Occupation	City & State of Residence	Contact How Often?

Please list below any children you have.

Name/Gender	Age	Please describe your relationship in a few words.

The following section will help to understand your needs and factors that may impact your life or therapy. Please indicate whether one or more of these experiences have ever happened to you.

- ☐ Adoption
- ☐ Alcohol Problem
- ☐ Chronic Medical Illness
- ☐ Divorce
- ☐ Emotional Abuse
- ☐ Foster Care
- ☐ Heavy Gambling
- ☐ Hospitalization (psychiatric)
- ☐ Hospitalization (physical)
- ☐ Taking Illicit Drugs
- ☐ Incarceration
- ☐ Infertility
- ☐ Job Layoff
- ☐ Legal Problems
- ☐ Money Problems
- ☐ Physical Fighting
- ☐ Prescription Drug Abuse
- ☐ Racial Discrimination
- ☐ Self-Mutilation
- ☐ Separation-Legal
- ☐ Sexual Abuse as Child
- ☐ Sexual Assault-Adult
- ☐ Suicide Attempt
- ☐ Suicidal Thoughts
- ☐ Unemployment
- ☐ War
- ☐ Worker's Comp.
- ☐ Domestic Violence

Current Difficulties & Areas of Needed Growth to Address

Please check the boxes below which **apply to you now** and are reasons for entering into therapy.

- ☐ Afraid of Being Independent
- ☐ Alcohol Problem
- ☐ Concerns about Coming Out
- ☐ Concerns about Emotional Stability
- ☐ Concerns about Hearing Voices or Seeing Things
- ☐ Concerns about Handling Finances
- ☐ Concerns about Job or Career
- ☐ Concerns about Physical Health
- ☐ Concerns about Feeling Mostly Numb
- ☐ Difficulty Controlling my Thoughts
- ☐ Difficulty in Sexual Relationships
- ☐ Difficulty in Sibling Relationship(s)
- ☐ Difficulty Making Decisions
- ☐ Difficulty Making or Keeping Friends
- ☐ Difficulties with Child(ren)
- ☐ Difficulties with Intimacy
- ☐ Difficulties with Parent(s)
- ☐ Difficulty with School
- ☐ Difficulty with Work
- ☐ Doing and Saying Things out of Anger a Lot
- ☐ Drug Problem
- ☐ Experiencing Guilty Feelings
- ☐ Experiences of Spaced Out Feeling
- ☐ Feeling Controlled or Manipulated
- ☐ Feeling Confused Much of the Time
- ☐ Feeling Constantly Self-Critical
- ☐ Feeling Cut-off from Emotions
- ☐ Feeling Depressed and Unhappy
- ☐ Feeling Inferior to Others
- ☐ Feeling Lonely
- ☐ Feeling Nervous or Anxious
- ☐ Feeling Stressed and Under Pressure
- ☐ Feelings Related to an Abusive History
- ☐ Feelings Related to Sexual Assault
- ☐ Getting into Trouble with Partner/Spouse
- ☐ Getting into Trouble with the Law
- ☐ Having Difficulty being Honest
- ☐ Having Difficulty Communicating Well
- ☐ Having Trouble Sleeping Well
- ☐ Having a Shopping Problem
- ☐ Lacking Self-confidence
- ☐ Physical Violence with my Partner
- ☐ Pre-marital Counseling
- ☐ Relationship Break-up
- ☐ Sexual Addiction
- ☐ Spiritual Disconnection
- ☐ Thoughts about Taking Own Life
- ☐ Trust Issues

In the space provided below, please tell me what symptoms you most want relief from, in order of highest important to address 1st, 2nd, 3rd, 4th, etc. Then, please tell me what you want more of in your life as a result of a successful therapy experience.