Name: **Intake Form**

Demographic Information

Date: _____ DOB: _____ Age: _____ Gender: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number(s): _____

Is it ok to leave a voicemail? *YES* *NO*

Email: _____

Would you like to receive email communication? *YES* *NO*

Is it ok to send something in the mail? *YES* *NO*

How were you introduced to us? _____

** Please complete below for additional client*

Name: _____

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1603 Capitol Avenue, Ste. 510A

Cheyenne, Wyoming 82001

662-419-3065

** Updated 4/2018, 6/2019*

Name: **Intake Form**

DOB: _____ Age: _____ Gender: _____

Birthplace: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number(s): _____

Is it ok to leave a voicemail? *YES* *NO*

Email: _____

Would you like to receive email communication? *YES* *NO*

Is it ok to send something in the mail? *YES* *NO*

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How Have We Come to Meet?

What are the 3 biggest concerns you have right now? How long have each been going on? Put them in order of importance:

1. _____
2. _____
3. _____

What do you think those that care about you would say their concern(s) is/are in regards to you?

_____
_____
_____

What solutions (helpful or unhelpful) have you tried to resolve your concerns?

_____
_____
_____

Have you had therapy in the past? If so, with whom and when? What reasons did you attend therapy for? Please share with us about your experience. What was helpful? unhelpful?

_____
_____
_____

Change is Coming…

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What are your expectations from therapy? What are your expectations of the therapist?

_____

_____

Looking into the future, how will you know that our work and time together has been worth it? List concrete changes you will see:

_____

_____

What other things would you like to see change in your life (family, career, health, relationships, etc.)?

_____

_____

Do you foresee any obstacles to achieving your goals or the desired changes?

_____

_____

How long do you think therapy will need to last to achieve your goals? Write down a target date:

_____

List 5 strengths about yourself or that others say about you, give examples of each:

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1. _____
2. _____
3. _____
4. _____
5. _____

Is there anyone that you would like to be a part of your sessions or think may be helpful to be part of sessions either now or in the future?

_____

Medical & Wellness Information

What do you do for wellness (i.e. healthy food choices, exercise, limits on TV/electronics/work, managing stress, family time, leisure, etc.)? Give examples:

_____

_____

How do you achieve balance in your life?

_____

_____

Have you ever received psychiatric services before? YES NO

If yes, how long ago, with whom, for what, medications prescribed and results:

_____

_____

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Do you have any allergies (food, environmental, medicinal, animal, etc.)

_____

Do you have any current or past medical issues, hospitalizations, accidents, injuries or surgeries? If yes, what?

_____

_____

Is there a family history of the above medical issues/concerns?

_____

_____

Are you presently under a physician's/psychiatrist's care? If so, for what reason?

_____

_____

Is there anyone in your life that is currently dealing with a medical issue that you are concerned about? If so, whom, for what?

_____

_____

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In the past year, have there been any changes in your life? (i.e.: moves, appetite, sleep, health, family, overall functioning)?

_____

_____

List any medications (over-the -counter & prescribed), nutritional or herbal supplements, or alternative treatments (acupuncture, chiropractic, etc.) you are taking/doing and the reasons:

_____

_____

Important Questions We Must Ask

Have you ever had thoughts of killing yourself? YES NO

If yes, please explain:

_____

_____

Have you ever planned on killing yourself? YES NO

If yes, please explain:

_____

_____

Have you ever attempted to kill yourself? YES NO

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If yes, please explain:

_____

_____

Has anyone in your family or close to you died by suicide? YES NO

If yes, please explain:

_____

_____

Have you ever felt you wanted to seriously harm or kill someone else? YES NO

If yes, please explain:

_____

_____

Do you have weapons in your home or access to weapons? YES NO

If yes, who has access to them and what are the safety protocols around them?

_____

_____

Is there any history or presence of abuse or violence? YES NO

If so, please explain:

_____

_____

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Are you currently using any illegal drugs or prescription medications in a way other than was prescribed, or is the reason you are seeking therapy services substance related?

_____

_____

Have you ever witnessed or experienced a trauma? Do you have reoccurring nightmares, flashbacks, or do you avoid anything that is uncomfortable or painful? If so, please explain:

_____

_____

Do you have currently legal issues or is the reason you are seeking therapy related to a court order? If so, please explain?

_____

_____

Career/Job, Recreation and Leisure

What is your current occupation? How would you describe your fulfillment of your job/career?

_____

_____

What is your highest level of education completed and field of study?

_____

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_____

What do you enjoy doing during your free/leisure time?

_____

_____

Intimate Relationships

If you are currently in a relationship, describe your relationship:

_____

_____

How would you describe your communication?

_____

_____

How would you describe intimacy and/or sex in your relationship?

_____

_____

* If you are in a relationship answer the following regarding your relationship:

1. Like _____
2. Dislike _____
3. Not enough of _____
4. Too much of _____
5. Ideal relationship _____

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Understanding Your Family & Influences

** Space left for therapist to draw family tree (genogram)*

Parent's marital status:

Married Divorced Never Married Separated Domestic Partners Widowed

Please describe your relationship with your parents:

_____

_____

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How would you describe your upbringing?

_____

_____

Who lives with you currently?

_____

_____

Do you have any pets? If yes, names, types and relationship to each pet:

_____

_____

Describe your relationship with the following:

Mother:

_____

Father:

_____

Mother's Significant Other:

_____

Father's Significant Other:

_____

Siblings: Age, Name and Sex:

a. Sibling 1

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b. Sibling 2 _____

c. Sibling 3 _____

Children:

a. Child 1 _____

b. Child 2 _____

c. Child 3 _____

Significant Other/Spouse:

_____

Relationships

Describe your relationship with your friends:

_____

_____

Who would you say your support system is (people, organizations, or affiliations)?

_____

_____

Do you belong to any religious or spiritual groups? YES NO

If yes, what is your level of involvement?

_____

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How do your religious or spiritual beliefs/practices influence your life?

_____

_____

Please list anything else that is important for us to know about you that would assist us in working with you to achieve your desired results:

_____

_____

_____

_____

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