Intake Form

Client_____________________________ Gender M______ F______ Current Date__________

Date of Birth________________ Age_______

Address________________________City_________________State_______Zip________

Phone_____________________________ E-Mail________________________________

Occupation__________________________Employer______________________________

Emergency Contact_________________________________Phone_______________

Religion____Ethnicity__________________

Marital Status__________ Name of Spouse _______________________________

Please list any children/ages

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____

How did you learn about us?

____

Current Medications

____

____

Physical Illnesses

____

____

____

Physician____

Have you previously received any type of mental health services in the past? If so, please list names of practitioners and dates

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How would you rate your current physical health?

Poor Unsatisfactory Satisfactory Good Very Good

How would you rate your current sleeping habits?

Poor Unsatisfactory Satisfactory Good Very Good

How many times per week do you generally exercise? ___________

What types of exercise do you participate in?

____

____

____

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?

____

____

____

Are you currently experiencing any chronic pain? If yes, please describe.

____

____

____

Do you drink alcohol more than once a week? _____ yes _______ no

How often do you engage in recreational drug use?

Daily Weekly Monthly Infrequently Never

Are you currently in a romantic relationship? If yes, for how long? ____

On a scale of 1-10, how would you rate your relationship? ____

Have you experienced any significant life changes or stressful events recently? Please describe:

____
____
____

Do you or anyone family members have a history of any of the following?

		Identify person affected
Alcohol/Substance Abuse	yes/no	
Anxiety	yes/no	
Depression	yes/no	
Eating Disorders	yes/no	
Obesity	yes/no	
Obsessive Compulsive Behavior	yes/no	
Schizophrenia	yes/no	
Suicide Attempts	yes/no	

What do you consider to be some of your strengths?

____
____
____

What do you consider to be some weakness?

____
____
____

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

____
____
____