

Client Intake Form

Name: DOB: Today's Date:

Address:

City: State: Zip: Preferred Phone:

Email: Referred By:

Emergency Contact Name: Relationship:

Phone: Permission to Call: Yes No Restrictions:

Marital Status: Single Married Partnered Divorced Widowed Other

Race/Ethnicity: Hispanic/Latino African American/Black/African/Caribbean Asian/Pacific Islander
 Caucasian Native American No Disclosure Other

Birth Sex: Male Female No Disclosure Other

Gender: Male Female Genderqueer Transgender No Disclosure Other

Preferred Pronouns: He/Him/His She/Her/Hers They/Them/Theirs Other



Medications:

Primary Care Provider: Phone:

Medical Illnesses/Surgeries:



Pregnancy History: #Live Births #Stillbirths #Miscarriages

Experienced the Loss of a Child

Nutrition Concerns:
Purge Yes No
Restrict Yes No
Overeat Yes No
Binge Yes No

Experiencing Pain: Yes No
Location of Pain:
How Long:
Medication for Pain:
Pain Level Today: 0 1 2 3 4 5 6 7 8 9 10 +

- Physical Symptoms:
- | | | |
|--|--|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Sexual Problems | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Muscle Tension | <input type="checkbox"/> Skin Problems | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Rapid Heartbeat | <input type="checkbox"/> Vision Changes |
| <input type="checkbox"/> Numbness | <input type="checkbox"/> Trembling/Shaking | <input type="checkbox"/> Blackouts |
| <input type="checkbox"/> Sweating | <input type="checkbox"/> Joint/Muscle Pain | <input type="checkbox"/> Chills/Hot Flashes |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Heat Pounding | <input type="checkbox"/> Stomach Aches |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Nausea |

Other:

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Top Three Stressors:

1.
2.
3.

Mood (Past 1-2 Weeks):

- Calm
- Happy
- Sad
- Angry
- Anxious
- Frustrated
- Worried
- Hopeless
- Helpless
- Excited
- Other

Behavioral Symptoms (Past Month):

- Sleep
- Enjoying Life
- Motivation
- Shame
- Guilt
- Concentration
- Racing Thoughts
- Loss of Sex Drive
- Impulsiveness
- Fatigue
- Poor Judgment
- Appetite Change
- Periods of High/Low
- Strange Thoughts
- Strange Behavior
- Low Energy
- Anxious
-
-
-
-
-

Notes:

Risk Assessment:

- Been so distressed you seriously wished to end your life?
- Do you have a specific plan how you would kill yourself?
- Do you have access to weapons/means of hurting self?
- Have you made a serious suicide attempt?
- Have you purposely done something to hurt yourself?
- Have you heard voices telling you to hurt yourself?
- Relatives who attempted or committed suicide?
- Thoughts of killing or seriously hurting someone?
- Heard voices telling you to hurt others?

	Yes	No	Recently	Today

Any hospitalizations for mental health purposes? Yes No

If yes, when and for what reason?

Have you had any previous counseling? Yes No

If yes, with whom and when?

Social History:

Are your parents divorced? Yes No

Briefly describe your childhood (happy, chaotic, troubled):

Are childhood events contributing to current problems? Yes No

Have you experienced any abuse (physical, sexual, verbal)? Yes No

How satisfied are you with your current family life? Satisfied Unsatisfied

How satisfied are you with the support received from family and friends? Satisfied Unsatisfied

How satisfied are you with your quality of life? Satisfied Unsatisfied

Do you enjoy leisure/recreational activities? Yes No Why/Why Not

Are you Spiritual? Yes No If yes, importance to you?

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Education/Work History:

Years of Education? Degree(s)?

How many jobs held? Been Fired? Yes No

Do you have performance problems or difficulties with boss? Yes No

How satisfied are you with your current occupation? Satisfied Unsatisfied

Substance Use/Abuse:

- Regularly use alcohol (more than twice a week)?
- Had trouble (legal, family, work) because of alcohol?
- Felt you should cut down on drinking?
- Felt bad or guilty about your drinking?
- Ever had a drink first thing in the morning?
- Use medications not prescribed to you?
- Taken more than the recommended daily dose?
- Used any product or other means to get "high"?

Yes	No	Past	Currently
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Habits:

Do you smoke or chew tobacco regularly? Yes No If so, how much?

Do you drink caffeinated drinks regularly? Yes No If so, how much?

Do you exercise on a regular basis? Yes No If so, how much?

Do you have problems with gambling? Yes No

Do you have other potentially harmful habits you want to change? Yes No

Describe



Reason for Seeking Therapy:

Goals for Therapy:

1.
2.
3.



Client Signature

Client Printed Name

Date

Legal Guardian Signature

Legal Guardian Printed Name

Date