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Name:_____ Date:_____

Client Intake Form

(Help me to get to know a little about you by filling out the following history form. It is important to be as complete as possible. Your responses will help me better understand why you are seeking help, and help insure our initial appointments can be as productive as they can be)

Why are you seeking help at this time? _____
_____

Did someone refer you to me? (circle one) *Yes No*

If "Yes", who referred you? _____

Are you currently working with a psychiatrist or another therapist? *Yes No*

If "Yes", please tell me who: _____
_____

Have you ever been in counseling or therapy before? *Yes No*

If "Yes", with whom and when: _____
_____

Are you taking psychiatric medications? *Yes No*

If "Yes", please list: _____
_____

Do you currently have trouble with anything listed below:

	Yes	***No***		***Yes***	***No***
Depression/Sadness			***Mood Swings***		
Anxiety/Excess Worries			***Excess Energy/Restlessness***		
Extreme Fear/Panic			***Anger or irritability***		
Phobias			***Racing thoughts or rapid speech***		
Repetitive thoughts/behavior			***Thoughts of harming/killing self***		
Appetite Changes			***Thoughts of harming/killing another***		
Low Energy			***Hallucinations***		
Memory/Concentration			***Other:***		

Have you ever attempted to hurt or kill yourself, or hurt or kill others? Yes No

If "Yes" Please explain: _____

Sleep Pattern

Do you currently have trouble with anything listed below:

	Yes	*No*		*Yes*	*No*
Falling asleep			***Wake feeling tired***		
Staying asleep			***Daytime sleepiness***		
Early Awakening			***Snoring***		
Disturbing dreams			***Sleep Apnea***		

<u>Medical</u>

Do you now have, or had, any of the following medical conditions? ("X" all that apply)

Asthma		***Cancer***		***Obesity***	
Cardiovascular		***Seizures***		***Fibromyalgia/CFS***	
Respiratory		***Brain or head injury***		***Thyroid disorder***	
High Blood Pressure		***Headaches***		***Vision Problems***	
Arthritis		***Pain Chronic or Acute***		***Hearing Problems***	
Diabetes		***Immune system***		***Eating Disorder***	
GI disorders		***Allergies***		***Other:***	

- ***Please list currently prescribed and over-the-counter medications:***
  _____
- ***_____***

<u>Alcohol/Substance Use History</u>

Do you drink alcohol or use other substances? (Indicate "Now" or in the "Past")

<u>Substance</u>	<u>Present</u>	<u>Past</u>	<u>Please describe how often and how much</u>
Caffeine			
Alcohol			
Marijuana			
Other:			

- ***Did you or anyone else ever think substance use was a problem for you?*** *Yes No*
- ***If "Yes", briefly describe: _____***
- ***If "Yes", hove you ever sought treatment for substance use?*** *Yes No*

<u>History of Trauma</u>

Have you ever experienced any of the following: (mark an "X" to all that apply)

Child physical abuse		***Crime Victim***	
Child sexual abuse		***Serious Accident or injury***	
Child emotional abuse/neglect		***House fire***	
Domestic violence		***Natural Disaster***	
Violent crime victim		***Other:***	

Educational History

How many years did you attend school: _____ Are you currently in school now? *Yes No*

Indicate highest degree & major? _____

Vocational

What is your usual occupation? _____

- ***Are you currently employed? Yes No***

Military

Do you currently or have you previously served in the military? *Yes No*

- ***If "Yes", what is your status: _____***
- ***If "Yes", are you a combat veteran?*** *Yes No*

Current Social

Currently : __Married __Partnered __Separated __Divorced __Widowed __Single

Family Member	***Name(s)***	***Current age***	***If deceased, cause of death***	***How do (did) you get along?***
Spouse/Partner				
Mother				
Father				
Siblings				
Children				

Legal

Are you currently involved in a divorce or child custody proceeding? *Yes No*

Are you currently or expecting involvement in other civil or criminal proceedings? *Yes No*

If yes, please explain: _____

_____