Psychotherapy Client Intake

The information on this form is protected as confidential information.

Date:_____

Name and any former names:_____

Legal Guardian if under age 18 and Mobile Phone:_____

Legal Guardian's Email Address:_____

Emergency Contact mobile phone, email address and relation to you (if different):_____

_____

_____

Your Address:_____

Your Mobile Phone number:_____ May we leave a message:_____

Email Address:_____ May we leave a message:_____

Note, these are not confidential methods of communication. Please instruct us accordingly if you wish for us to not message you details, and only general information when we message you.

Referred by:_____

DOB:_____ Age:_____

Gender/Sex (answer any way you would like to answer):_____

_____

Ethnicity/Culture/Heritage (answer any way you would like to answer):_____

_____

You can answer the following questions briefly and star answers that we should more deeply discuss during intake session.

Please list significant birth or childhood experiences/conditions:_____

_____

Relationship Status and how long?:_____

How would you rate your relationship (feel free to give details)?:_____

_____

Please share any thoughts that come to mind regarding your sex life and sexuality:_____

_____

Please share any recent life changes or stressful events (including chronic stress):_____

_____

What mental health services have you had and your experience with them?:_____

_____

Previous diagnoses:_____

What do you think your mental health challenges are?:_____

_____

What traumas have you experienced (including suicidal attempts or thoughts)?:_____

_____

Are you currently experiencing overwhelming depression/grief/sadness, anxiety/panic/phobias, or other (specify and for how long)?:_____

_____

What current challenging behaviors do you display?_____

_____

What medications have you taken (or why were they prescribed) with approximate dates?:_____

_____

What medications are you currently taking and how long?:_____

_____

How would you rate your current physical health?:_____

_____

What specific physical health challenges are you facing, include chronic pain?:_____

_____

How would you rate your sleep experiences and what does a typical night or typical week of sleep look like?:_____

_____

How many times per week do you exercise and what does this look like?:_____

_____

What difficulties do you experience with appetite, eating, digesting, eliminating?:_____

_____

Please describe alcohol and drug use (past or present, and how often):_____

_____

Please list family members mental health challenges or diagnosis (Alcohol and Other Drug Abuse, Anxiety, Depression, Domestic Violence, Eating Disorders, Obesity, Obsessive Compulsive Behavior, Borderline, Bipolar, Schizophrenia, Suicide Attempts, etc.):_____

_____

Please share current stressors from family members you have:_____

_____

Are you employed or working and what do you find enjoyable and stressful?:_____

_____

How do you spend your days or nights (non-sleeping time)?:_____

_____

Please describe your faith or spirituality:_____

_____

What are some of your strengths?:_____

_____

What are some of your weaknesses?:_____

_____

Primary reason for scheduling today?:_____

_____

What would you like to accomplish in Therapy?:_____

_____

How often would you like to schedule and ideal time frame:_____

_____

Coping Mechanisms and support system:_____

_____

What are the Hobbies/Creativity you enjoy:_____

Thank you for your time and thoughtfulness (I know this form contains is a lot of deep, personal questions)! I really want to get to know all about you and your life!