Client Intake Form

Name: DOB: Date:

Age: Gender: M F

Address: City: State: Zip:

Contact No. Leave a msg: Yes No Email:

Marital Status: Married Un-Married Divorced Separated Widowed Other:

Referred By:

Have you received any mental health services/psychotherapy before? Yes No

Provide Details:

Are you currently taking any medications? Yes No

Please List:

General Health & Mental Health

Physical Health:	Very Good	Good	Satisfactory	Poor	Very Poor
Sleeping Habits:	Very Good	Good	Satisfactory	Poor	Very Poor
Eating Habits:	Very Good	Good	Satisfactory	Poor	Very Poor

Are you currently experiencing overwhelming grief, sadness, or depression? Yes No

Are you currently experiencing anxiety, panic attacks or any problems? Yes No

Are you currently experiencing any pain? Yes No

Do you drink alcohol more than once a week? Yes No

Do you engage yourself in recreational drug use? Yes No

If yes, how often? Daily Weekly Monthly Infrequently

Are you currently in a relationship? Yes No

On a scale of 1-10 how would you rate your relationship? 1 2 3 4 5 6 7 8 9 10

Physical Symptoms:

Headache	Stomach Ache	Other:
Chest Pain	Vomiting	
Muscle Tension	Skin Problems	
Palpitations	Rapid Heart Beat	
Sweating	Heart Pounding	
Trembling/Shaking	Muscle/Joint Pain	
Dizziness	Shortness Of Breath	
Fatigue	Fainting	
Jaw Clenching	Flushes	
Vision Changes	Sexual Problems	
Nausea	Tingling	
Diarrhea	Numbness	

Behavioral Symptoms:

Anxiety Attacks	Racing Thoughts	Other:
Sleep Disturbance	Feeling Low	
Appetite Changes	Low Energy	
Eating Problems	High Energy	
Lack Of Focus	Low Self-Esteem	
Lack Of Motivation	Withdrawal	
Impulsiveness	Indecisiveness	
Fatigue	Crying	
Poor Judgement	Enjoying Life	
Strange Thoughts	Periods of High/Low	
Strange Behavior	Memory Problem	
Lack Of Interest	Nervousness	

Emotions/Mood:

Calm	Confused	Other:
Agitated	Panic	
Happy	Lonely	
Sad	Nervous	
Energetic	Worried	
Excited	Irritated	
Hopeless	Angry	
Helpless	Elevated	
Shame	Guilt	
Regret	Tense	

Education/Work History:

Year Of Education: _____ Degree: _____

Current Occupation: _____ Job Duration: _____

How satisfied you are with your current job on a scale of 10? 1 2 3 4 5 6 7 8 9 10

How many jobs you have been into? _____

Which job did you enjoy the most? _____

Are you currently looking to change your job? Yes No

Whatis the reason to change your job? _____

Personal/Social History:

How was your childhood? _____

Were you raised by a single parent?	Yes	No	_____
Have you experienced emotional abuse?	Yes	No	_____
Have you experienced sexual abuse	Yes	No	_____
Have you experienced any childhood trauma?	Yes	No	_____
Have you experienced any personal losses recently?	Yes	No	_____

Risk Assessment:

Have you thought to end your life recently?	Yes	No	_____
Do you have access to means/weapons to kill yourself?	Yes	No	_____
Do you have any specific plan to kill yourself?	Yes	No	_____
Have you ever attempted suicide previously?	Yes	No	_____
Have you ever attempted to hurt someone?	Yes	No	_____
Do you hear voices telling you to kill yourself?	Yes	No	_____
Do you hear voices telling you to kill someone?	Yes	No	_____
Anyone in the family attempted suicide?	Yes	No	_____

Family Mental Health History:

			Specify Relationship
Anxiety	Yes	No	_____
Depression	Yes	No	_____
Alcohol/Drug Abuse	Yes	No	_____
Eating Disorder	Yes	No	_____
BiPolar Disorder	Yes	No	_____
Obsessive Compulsive Disorder	Yes	No	_____
Suicidal Thoughts	Yes	No	_____
Schizophrenia	Yes	No	_____
Domestic Violence	Yes	No	_____
ADHD (Attention Deficit/ Hyperactivity Disorder)	Yes	No	_____
PTSD (Post-Traumatic Stress Disorder)	Yes	No	_____

Reason for Seeking Therapy:

Goals for Therapy:

Client Name:

Client Signature:

Date: _____