Client Intake 1

Name	DOB

Please provide the following information for our records. Leave blank any question you would rather not answer. Information here is held to the same standards of confidentiality as our therapy. Please print this out and bring it you your first session. Thank you!

Are you currently receiving psychiatric or other counseling services elsewhere?	Y ____ N ____
Have you had previous experience in psychotherapy?	Y ____ N ____
Are you currently taking prescribed psychiatric medication?	Y ____ N ____

HEALTH AND SOCIAL INFORMATION

Are you currently in a romantic relationship? Y ____ N ____ If yes, how long? _____
How is your physical health at present? _____
Please list any physical symptoms or health concerns (chronic headaches, diabetes, pain, etc) _____
How often do you exercise? _____ If you engage in exercise, what kind? _____
Are you having difficulty with eating or appetite? _____ Have you had significant weight change in the last 2 months? _____
Are you having trouble sleeping? Y ____ N ____ If yes, please describe: _____
Do you regularly use alcohol? Y ____ N ____ If yes, what quantity and frequency : _____
Do you use drugs recreationally? Y ____ N ____ If yes, how often? _____
Have you had suicidal thoughts recently? Y ____ N ____ Have you had them in the past? Y ____ N ____

Client Intake 2

Please list any significant life stressors or changes you have experienced in the last year:

_____

_____

_____

_____

FAMILY MENTAL HEALTH HISTORY

	If yes, who?		If yes, who?
Depression		Bipolar Disorder	
Anxiety		Panic Attacks	
Schizophrenia		Alcohol/Substance Abuse	
Eating Disorders		Learning/Developmental Disabilities	
Trauma History		Suicide Attempts	

OCCUPATIONAL INFORMATION

Are you currently employed?	Y ____ N ____
If yes, do you enjoy what you do?	
Please list any work related stressors, if any:	

RELIGIOUS/SPIRITUAL INFORMATION

Do you consider yourself to be religious?	Y ____ N ____
If yes, what is your faith?	
Do you consider yourself to be spiritual?	Y ____ N ____