CLIENT INTAKE FORM

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Please take your time in providing the following information. If you are completing this paperwork for a minor, have the minor be as involved as developmentally possible. If the minor is able to fill out the paperwork on their own please note any perspective that may differ from the minors perspective. My goal is to gather as much information as possible so I can best understand my client. Client perspective as well as teacher, parent, sibling, or caregiver perspective can be equally as helpful in gathering the client story.

Date of first appointment: ____________________________

Name: ____

Present at first session: ____

Completed by: ____

Therapist notes added by (this will be completed by therapist): _________________________________

Referred by:

☐ Medical Provider: ________________________

☐ Insurance Provider: ______________________ ☐ Internet

☐ Friend/Family: ___________________________ ☐ Other: _______________________

Have you previously received any type of mental health services?

☐ Yes ☐ No

If yes, which of the following:

☐ Counseling/Therapy ☐ Medication

☐ Outpatient Programs ☐ Inpatient Hospitalization

❑ psychological testing

Name of provider or facility:____

Dates of treatment:____

Reason for treatment:____

School and/or Employment

Answer the questions below that currently apply to you.
If you are not currently in school or working you may skip that section and just answer highest schooling to date.

Highest Schooling to Date: ____

School: ____ Grade: ______________

504 or IEP: ____

Any changes in schools? ____

Do you feel successful in school, and why or why not? (parent perspective can also be added here):

Are you Employed: ____

Full or part time:____

History of employment: (include job changes due to lay off or being let go):

Physical Health

Please list any medications, herbs, or supplements. Be sure to include the condition, as some medications are prescribed for off-label use. Continue on the back if needed, or provide a separate list.

Medication/Supplement or history of	**prescribing doctor**	**Condition**	**Date Began/Stopped (approx. date)**

Doctor: ____

Psychiatrist: ____

Other relevant practitioners: ____

How would you rate your current physical health?

- ☐ Poor
- ☐ Unsatisfactory
- ☐ Satisfactory
- ☐ Good
- ☐ Very Good

Please list any specific health problems you are currently experiencing:

Childhood illness, trauma, or head injuries?

Sleep and Exercise

How would you rate your current sleeping habits?

- ☐ Poor
- ☐ Unsatisfactory
- ☐ Satisfactory
- ☐ Good
- ☐ Very Good

If you are having problems tell about your problems? Falling asleep, staying asleep, sleep apnea, sleep walking or talking, do not feel rested after sleep? Anything else?

How many times per week do you generally exercise? ____________ What types of exercise do you participate in:

Are you currently experiencing any chronic pain?

- ☐ No
- ☐ Yes

If yes, please describe:

Nutrition

How would you describe your current dietary patterns:

Do you eat meals and snacks daily and does it include a balanced diet?

Do you skip meals?

Are you on any special diet?

Are you currently restricting calories, or binge purging?

Do you have a history of disordered eating behaviors or have been treated for an eating disorder?

Please describe current use, and or previous use of alcohol, cigarettes, and/or recreational drugs:

Family History

Where were you born? ____

Have you lived in several different places? If so tell me about that:

Marital Status:

☐ Never Married
☐ Married : For how long?___________
☐ Divorced -- For how long?__________
☐ Domestic Partner: For how long? ___________
☐ Separated: For how long? ________________
☐ Widowed: Please provide your partners name and year decease
____

Please list your parents, siblings, and others living in the home. If you are an adult list others in the home when you were growing up. If you are involved in a custody agreement list others in the agreement including adults as well as all children. (For example, step-children, or children/siblings living away)

Name	**Age**	**Relationship**	**Where do they live now?**	**If deceased, age and cause of death**

Mother's occupation: ____

Father's occupation? ____

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

Condition	**Please circle**	**List Family Member**
Alcohol/Substance Abuse	yes/no	
Anxiety	yes/no	
Depression	yes/no	
Domestic Violence	yes/no	
Sexual Abuse	yes/no	
Eating Disorders	yes/no	
Obesity	yes/no	
Obsessive Compulsive Disorder	yes/no	
Schizophrenia	yes/no	
Suicide Attempts	yes/no	
Other diagnosed mental health condition?	yes/no	

What Brings You In Today

What are your goals, expectations, or aims for treatment?

When did your problem first start? Within the last:

- ☐ 30 days
- ☐ 6--12 months
- ☐ 2 years
- ☐ During adolescence
- ☐ During childhood

What areas of your life have been affected because of this problem?

Are you currently experiencing or have a history of panic attacks? yes / no

If so, when did you begin experiencing this, and how often does it occur?

Are you currently experiencing or have a history of manic episodes? yes / no

If so, when did you begin experiencing this, and how often does it occur?

Are you experiencing or have a history of depressive episodes? yes / no

If so, when did you begin experiencing this, and how often does it occur?

Are you having or have you experienced obsessions or compulsions? yes / no

If so, when did you begin experiencing this, and how often does it occur?

Are you currently having suicidal or homicidal ideations? yes / no

Do you have a history of suicidal or homicidal ideations, or attempts of suicide? yes / no
If you said yes, tell me more about that:

Are you currently having urges or actions of self harm? yes / no
If you said yes, tell me more about that:

Do you have a history of using self-harm as a means for coping? yes / no
If you said yes, tell me more about that:

Have you ever been arrested? yes / no
If yes, please tell me about that:

Do you have a history of abuse in your story? yes / no
(physical, sexual or emotional) **If you feel comfortable telling me anything about this you may, if not, feel free to tell me you are not comfortable discussing it at this time.**

Please describe any major losses, changes or traumas you have experienced:
(deaths of loved ones, moves, job changes, etc.)

Tell me about your social supports, and or religious affiliations:

Mental Status
****To be completed by Therapist***

Appearance
___ client not in session
__ groomed ___ ungroomed
___ neatly dressed ___ erect
___ slouched posture ___ cooperative
___ uncooperative ___ inappropriate
___ appropriate

Speech
___ client not in session
___ congruent ___ incongruent
___ slurred ___ rapid
___ verbose ___ monotone

Mood
___ client not in session
___ Mad/angry/agitated/irritable ___ sad/depressed
___ anxious/nervous/worried ___ apathetic
___ physical ailment ___ euthymic
___ euphoria

Affect
___ client not in session
___ bright ___ euthymic
___ flat ___ constricted
___ appropriate ___ tired
___ inappropriate

Orientation
___ client not in session
___ intact
___ not intact

Thought Content
___ client not in session
___ consistent with affect ___ clear and coherent
___ Paranoid ___ phobic
___ obsessive ___ delusional

Thought Process
___ client not in session ___ logical
___ illogical ___ clear and coherent
___ flight of ideas ___ unorganized
___ rapid

Memory
___ client not in session
___ short term intact ___ short term not intact
___ long term intact ___ long term not intact

Judgement
___ client not in session
___ good
___ poor
___ fair

Insight
___ client not in session
___ good
___ poor
___ fair

Axis I: ____

Axis II: ____

Axis III: ____

Axis IV: ____

Axis V: ____