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CLIENT INTAKE FORM

GENERAL DEMOGRAPHICS:

Name: _____ **Today's Date**: _____/_____/_____
(Last) (First) (MI) (Month) (Day) (Year)

Birth Date: _____/_____/_____ **Age:** _____ **Gender:** ☐ Male ☐ Female **Social Security #:**_____
(Month) (Day) (Year)

Home Address: _____
(Street and Number) (City) (State) (Zip Code)

Mailing Address: _____
(Street and Number) (City) (State) (Zip Code)

Which Address Is Used For Insurance/Billing Purposes? ☐ Home ☐ Mailing

Home Phone: __(_____)_____ **May I leave a message at this number?** ☐ Yes ☐ No

Cell Phone: ____(_____)_____ **May I leave a message at this number?** ☐ Yes ☐ No

Work Phone: __(_____)_____ **May I leave a message at this number?** ☐ Yes ☐ No

What is your preferred contact phone number? ☐ Home ☐ Cell ☐ Work

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Are You Employed? ☐ Yes ☐ No If yes, Employer: _____ Job Title: _____

Are You A Student? ☐ Yes ☐ No If yes, School Name: _____

Emergency Contact Name: _____ **Relationship:** _____
(Last) (First)

Emergency Contact Phone: __(_____)_____

Where Did You Find My Name? _____

Referring Physician (if applicable): _____

HEALTH INSURANCE/BILLING INFORMATION:

Patient Relationship To Insured: ☐ Self ☐ Spouse ☐ Partner ☐ Other **Insured's Gender:** ☐ Male ☐ Female

Insured's Name: _____ **Insured's Birthdate** _____/_____/_____
(Last) (First) (MI) (Month) (Day) (Year)

Primary Insurance Name: _____ **ID#:** _____ **Group #** _____

Secondary Insurance Name: _____ **ID#:** _____ **Group #** _____

CLIENT INTAKE FORM con't.

PROBLEM ANALYSIS:

Problem Description: Please describe, in brief terms, the nature of the problem or concern that you need help with:

_____

Problem Intensity: How would you rate the intensity of the problem or concern that you have?

☐ Not Intense ☐ Somewhat Intense ☐ Moderately Intense ☐ Quite Intense ☐ Very Intense

Problem Duration: Approximately how long has your problem or concern been going on? _____

Symptom List: Please indicate which of the following symptoms, emotions, feelings, or behaviors apply to you.

☐ Hopeless	☐ Sad	☐ Change in Appetite	☐ Thoughts of Hurting/Killing Yourself/Others
☐ Anxious	☐ Panicky	☐ Change in Sleeping Habit	☐ Change in Sexual Interest/Function
☐ Depressed	☐ Tearful	☐ Hear/See Strange Things	☐ Problem With Interpersonal Relationships
☐ Angry	☐ Forgetful	☐ Extreme Happiness/Sadness	☐ Purging (Self-Induced Vomiting)

Coping Attempts: Please describe by what manner or means you have attempted to cope with your problem or concern.

_____

GENERAL HEALTH & MEDICAL ISSUES:

How would you describe your physical health? ☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very Good

Do you have any persistent medical problems/health concerns (e.g. chronic pain, diabetes, etc.)? ☐ Yes ☐ No

Are you currently taking any prescription medication to treat a medical condition? ☐ Yes ☐ No

If yes, please indicate what medication and how long you have been taking it (insulin/3 years, etc.):

_____

If you are taking prescription medication, who prescribed it to you? _____

(Last) (First)

How many times per week do you exercise? _____ **For about how long each time?** _____

PSYCHIATRIC HISTORY:

Are you currently receiving psychiatric treatment or psychological counseling elsewhere? ☐ Yes ☐ No

If yes, what is the name of your counselor, how long have you been receiving treatment, and for what reason?

_____

Have you ever received psychiatric treatment or psychological counseling in the past? ☐ Yes ☐ No

If yes, what was the name of your counselor(s), when were you in treatment, for how long, and for what reason?

_____

Have you ever been hospitalized in a psychiatric treatment facility in the past? ☐ Yes ☐ No

If yes, where were you hospitalized, for how long, and for what reason?

_____

Are you currently taking any prescribed psychiatric medication? ☐ Yes ☐ No

If yes, what is the name and dose of the medication(s), how long have you been taking it, and for what reason?

_____

If you are not currently taking prescription medication, have you ever done so in the past? ☐ Yes ☐ No

If yes, what was the name of the medication(s), how long were you taking it, and for what reason?

_____

CLIENT INTAKE FORM con't.

PERSONAL/CULTURAL BACKGROUND:

Education:

Did you graduate from high school? ☐ Yes ☐ No ☐ (child) If not, please indicate highest grade completed: _____

Have you ever attended a college or university? ☐ Yes ☐ No If so, did you graduate? ☐ Yes ☐ No

Please indicate the type of degree that you may possess: ☐ AA ☐ BA/BS ☐ MA/MS ☐ Other _____

Military:

Have you ever been a member of the Military? ☐ Yes ☐ No If so, are you currently on active duty? ☐ Yes ☐ No

What is your current, or what was, your rank? _____

Ethnicity:

What is your ethnic identity? _____

How much do you identify with your heritage? ☐ Not at all ☐ A little ☐ Somewhat ☐ Moderately ☐ Strongly

Religion:

Do you consider yourself a religious person? ☐ Yes ☐ No If so, what is you religious preference? _____

Are you currently active in your religion? ☐ Yes ☐ Somewhat ☐ Not at all

Family History:

Do you have any children? ☐ Yes ☐ No If so, please list gender and ages (e.g. son/4, daughter/8, etc.):

_____

Do you have any stepchildren? ☐ Yes ☐ No If so, please list gender and ages (e.g. son/4, daughter/8, etc.):

_____

Please list the identity and age of all *living* members of your immediate family (e.g. father/65, wife/28, brother/21, etc.):

_____

Please list the identity and age of all *deceased* members of your immediate family (e.g. father/65, wife/28, brother/21, etc.):

_____

Please check any past, present, or impending special problems in your family:

☐ divorce ☐ debilitating injuries/disabilities ☐ alcohol/drug abuse ☐ psychiatric disorder ☐ serious illness

☐ physical/sexual abuse ☐ financial crisis/unemployment ☐ legal problems ☐ attempted/completed suicide

☐ eating disorders ☐ other (please specify) _____

Please specify family member(s), special problem, and approximate year of occurrence (e.g. father/disability/1997):

_____

_____

Have you personally experienced significant family abuse? ☐ No ☐ Unsure ☐ Emotional ☐ Physical ☐ Sexual

How happy or adjusted were you growing up? ☐ Not very ☐ Somewhat ☐ Average ☐ Above average ☐ Very

How much is your immediate family a source of emotional support for you?

☐ Not at all ☐ A little ☐ Somewhat ☐ Substantial ☐ Very much so

Who in your family do you currently feel closest to? _____

Who in your family do you currently feel most distant from? _____

Who in your family do you feel most in conflict with? _____