Client Intake

Please provide the following information for our records. Leave any question blank you would rather not answer or would prefer to discuss with your therapist. The information you provide here is held to the same standard of confidentiality as our therapy.

Name *

First Name Last Name

Pronouns

Gender

Sex

Today's Date *

Month Day Year

Birthdate *

Month Day Year

Please list the ethnicities, cultures, and races you identify as:

Email *

example@example.com

Can I contact you at this email? *

- ◯ YES
- ◯ NO

Phone Number *

Area Code | Phone Number

Can I contact you at this phone number? (Phone call and/or text) *

- YES
- NO

Can I leave a voicemail at this phone number? *

- YES
- NO

How did you hear about me? *

Emergency Contact *

First Name | Last Name

Emergency Contact Phone Number *

Area Code | Phone Number

Emergency Contact Address *

Street Address

Street Address Line 2

City | State / Province

Postal / Zip Code

Emergency Contact Nature of Relationship (parent, partner, friend, etc.) *

Name of Parent or Guardian (if you are a minor)

First Name | Last Name

Phone Number of Parent or Guardian (if you are a minor)

Area Code | Phone Number

Address of Parent or Guardian (if you are a minor)

Street Address

Street Address Line 2

City | State / Province

Postal / Zip Code

Treatment History

Are you currently seeing another mental health provider? (psychiatrist, psychologist, counselor, therapist, etc.)

- ◯ YES
- ◯ NO

If yes, name of professional(s)

Please provide the following information if you have had any previous counseling, therapy, hospitalizations, treatment, or inpatient care.

	Dates in Treatment	Name of Therapist/Program	Issues Addressed	Diagnosis at the Time
1.				
2.				
3.				
4.				

Are you currently taking any medications?

- ◯ YES
- ◯ NO

If yes, please list medication type, dose, frequency and prescribing physician.

Health and Social Information

Do you have any allergies?

- ◯ YES
- ◯ NO

If yes, please describe.

Do you have a current primary physician?

- ◯ YES
- ◯ NO

If yes, who is it?

Do you see more than one medical health specialist?

- ◯ YES
- ◯ NO

How would you describe your physical health at this time?

Please list any persistent physical or medical concerns (e.g. chronic pain, hypertension, diabetes, etc.)

Are you currently taking any medications to manage a physical health concern? If yes, please list.

Are you currently satisfied with your sleep patterns?

- ◯ YES

○ NO

If no, please check (as many as applicable):

- ☐ Sleeping too much
- ☐ Sleeping too little
- ☐ Difficulty falling asleep
- ☐ Difficulty staying asleep
- ☐ Poor quality sleep
- ☐ Disturbing dreams
- ☐ _____

How many times per week do you exercise?

_____

Approximately how long does each exercise session last?

_____

Are you having difficulty with appetite or eating habits?

- ○ YES
- ○ NO

Type a question

- ☐ Eating too much
- ☐ Eating past fullness
- ☐ Not having enough money for food
- ☐ Purging (throwing up, laxative use, etc.)
- ☐ Night eating
- ☐ Constant dieting
- ☐ Fear of gaining weight
- ☐ Obsessions or constant thoughts about food
- ☐ Fear of throwing up
- ☐ Feeling hungry all the time
- ☐ Avoiding certain foods or types of foods (carbs, fats, "sweets," etc.)
- ☐ Excessive fluid consumption
- ☐ Eating the same thing all the time
- ☐ _____
- ☐ Eating too little
- ☐ Not having enough food around
- ☐ Restricting
- ☐ Bingeing
- ☐ Using food to cope
- ☐ Constant thoughts or worries about food
- ☐ Fear of food
- ☐ Extreme picky eating
- ☐ Not feeling hungry
- ☐ Hiding food
- ☐ Dehydration
- ☐ Allergies/Intolerances
- ☐ Fear of eating food from a restaurant

Have you experienced a significant weight change in the past two months?

- ◯ YES
- ◯ NO

In a typical month, how often do you have 4 or more drinks in a 24-hour period?

Do you use marijuana, heroin, cocaine, meth, or prescription drugs not prescribed to you?

- ◯ YES
- ◯ NO

If yes, how often do you use the drug(s)?

- ◯ Daily
- ◯ Weekly
- ◯ Monthly
- ◯ Rarely
- ◯ Never
- ◯ _____

Do you smoke cigarettes or use other tobacco products (including vaping)?

- ◯ YES
- ◯ NO

If yes, how often do you smoke cigarettes or use other tobacco products?

- ◯ Multiple times per day
- ◯ Daily
- ◯ Weekly
- ◯ Monthly
- ◯ Rarely
- ◯ Never
- ◯ _____

How often do you gamble?

- ○ Multiple times per day
- ○ Daily
- ○ Weekly
- ○ Monthly
- ○ Rarely
- ○ Never
- ○ _____

Has anyone ever told you they were concerned about your eating, drinking/drug use, or gambling habits?

- ○ YES
- ○ NO

If yes, what was their concern?

_____

Have you had suicidal thoughts recently?

- ☐ Frequently
- ☐ Sometimes
- ☐ Rarely
- ☐ Never
- ☐ _____

Have you had suicidal thoughts in the past?

- ☐ Frequently
- ☐ Sometimes
- ☐ Rarely
- ☐ Never

Are you currently or have you been pregnant in the past?

- ○ YES
- ○ NO

If you are currently pregnant, please indicate the date your last menstrual period began.

_____ _____ _____

If you have been pregnant in the past, please write the dates and nature of the pregnancy and birth (e.g. miscarriage, abortion, stillbirth, live birth, twins, c-section, etc.) If you have living or deceased children, please write their name(s), age(s), date of death (if applicable), cause of death (if known).

Date of your last delivery.

Month Day Year

Type of delivery

Please check all pregnancy-related or birth "complications."

- ☐ Gestational Hypertension
- ☐ Low blood pressure
- ☐ Breech
- ☐ Trouble gaining weight
- ☐ Preeclampsia/Eclampsia/Toxemia
- ☐ Breech positioning baby
- ☐ Placenta previa or placenta accreta
- ☐ Multiple miscarriages
- ☐ Low amniotic fluid (oligohydramnios)
- ☐ Etopic pregnancy
- ☐ Emergency cesarean
- ☐ Induction
- ☐ Provider neglect/abandonment
- ☐ Other pain
- ☐ Depression
- ☐ Gestational Diabetes
- ☐ Cholestasis
- ☐ Genetic/developmental Issues
- ☐ HELLP syndrome
- ☐ Preterm labor
- ☐ Twin pregnancy/multiple pregnancy
- ☐ Infertility/difficulty conceiving
- ☐ Full term loss
- ☐ PCOS
- ☐ Unnecessary cesarean
- ☐ Planned cesarean
- ☐ Provider abuse/maltreatment
- ☐ Sciatica pain
- ☐ Anxiety
- ☐

Please check all postpartum "complications" that apply.

- ☐ Depressed mood
- ☐ Hypertension
- ☐ Incision pain
- ☐ Leaking
- ☐ Trouble breastfeeding
- ☐ Physical pain
- ☐ Feeling inadequate
- ☐ Thoughts of dying
- ☐ Intrusive/unpleasant/disturbing thoughts
- ☐ Excessively anxious mood
- ☐ Hospitalization(s)
- ☐ Pelvic pain
- ☐ Trouble bonding
- ☐ Mastitis
- ☐ Infection
- ☐ Thoughts of hurting or killing self
- ☐ Thoughts of hurting or killing baby
- ☐ _____

Please check all baby's "complications" that apply.

- ☐ Difficulty feeding
- ☐ Crying all the time
- ☐ GERD
- ☐ Congenital heart defect
- ☐ NICU stay
- ☐ Down Syndrome
- ☐ Cleft palate
- ☐ Difficulty sleeping
- ☐ Medical complications
- ☐ Tongue/lip tie
- ☐ Prematurity
- ☐ Microtia
- ☐ Genetic deformity
- ☐ _____

Are you currently in a romantic relationship?

- ○ YES
- ○ NO

With whom is this current relationship? Write name(s) and age(s).

_____

If yes, how long have you been in this relationship?

_____

- ○ Weeks
- ○ Months
- ○ Years

In the past year, have you experienced any significant life changes (positive or negative) or life stressors? If yes, please describe.

In your lifetime, have you ever experienced something you would describe as "traumatic?" If yes, please describe and list date(s).

Have you ever experienced the following? Check all the apply.

- ☐ Extreme depressed mood
- ☐ Extreme Anxiety
- ☐ Sleep disturbances
- ☐ Memory lapses
- ☐ Frequent body complaints
- ☐ Eating disorder
- ☐ Homicidal thoughts
- ☐ Self-harm actions (scratching, burning, cutting)
- ☐ Dramatic mood swings
- ☐ Panic attacks
- ☐ Hallucinations
- ☐ Traumatic brain injuries
- ☐ Body image issues
- ☐ Repetitive thoughts (e.g. obsessions)
- ☐ Suicidal thoughts
- ☐ Domestic violence
- ☐ Rapid speech
- ☐ Phobias
- ☐ Unexplained losses of time
- ☐ Alcohol/substance abuse
- ☐ Self-esteem issues
- ☐ Repetitive behaviors (e.g. frequent checking)
- ☐ Self-harm thoughts
- ☐ Abuse (sexual, physical, emotional, financial)
- ☐

If you checked any of the above, please list dates for each symptom as well as if you are currently experiencing them. (Example: Eating disorder, 2015 to present, Extreme Anxiety, 2012-2015).

Occupational History

Are you currently employed?

If yes, please name current employer and

- ◯ YES
- ◯ NO

position.

Have you ever been fired from a job?

- ◯ YES
- ◯ NO

If yes, what was the reason(s)? Where were you employed?

Do you currently receive social security?

- ◯ YES
- ◯ NO

Religious and Spiritual Information

Do you consider yourself religious?

- ◯ YES
- ◯ NO

Do you consider yourself spiritual?

- ◯ YES
- ◯ NO

If yes, what is your faith?

If yes, what types of worship, communities, or practices do you engage in? (Example: going to church or praying, chanting, etc.)

Family Mental Health History

Please list your mother, father, stepfamily, friends, and/or relatives who have/had a significant (positive or negative) impact on your life.

	Name	Sex	Age	Year of death	Relationship to you	Describe the person
1.						
2.						
3.						

4.
5.
6.
7.
8.

Please identify any of the following you experienced in your family:

- ☐ Physical abuse
- ☐ Sexual abuse
- ☐ Emotional abuse
- ☐ Financial abuse
- ☐ Drug/alcohol dependence/addition
- ☐ Gambling
- ☐ Multiple marriages
- ☐ Divorce
- ☐ Major losses
- ☐ Poverty
- ☐ Sibling Struggles

Has anyone in your family ever experienced the following? Please check all that apply.

- ☐ Autism
- ☐ Bipolar Disorder
- ☐ Panic attacks
- ☐ Alcohol/substance abuse
- ☐ Learning disability
- ☐ Suicide attempts
- ☐ Chronic illness
- ☐ Domestic violence
- ☐ Depression
- ☐ Anxiety Disorder
- ☐ Schizophrenia
- ☐ Eating disorders
- ☐ Trauma history
- ☐ Suicide deaths
- ☐ Gambling addiction
- ☐

If yes, who? (Example: Depression = mother, suicide death, depression = father)

Other Information

What do you consider to be your strengths?

What do you like about yourself?

What are effective coping strategies you have learned?

Therapy Agreement

- [ ] I have received, read, and understand the Therapy Agreement and Privacy Policy.
- [ ] I have read and agree to abide by the Safety Contract at all times.

Name

First Name Last Name

Date

Month Day Year

Typing my name in the above box is the equivalent of offically signing a document.

Treatment Plan

Problem (Why I'm here, what I've tried, what makes it better, what makes it worse)

Goals (what I want)

Objective (how I know I am making progress)