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Client Intake Form

Today's Date:_____ Date of Birth:_____
Phone:_____ Place of Birth:_____
Name:_____ ☐ Female ☐ Male
Address:_____
_____
Who referred you?_____
Contact Person in Case of Emergency:_____
Address:_____
_____
Relationship to you:_____ Phone:_____

Are you employed? ☐ Yes ☐ No
If yes, where?_____
How long?_____
If less than a year, where were you previously employed?_____
When/How long?_____
If unemployed, how long?_____ Why?_____
_____
_____

Do you live alone? ☐ Yes ☐ No How long at current residence?_____
How many times have you moved in the last 2 years?_____
If you have moved more than two times, why?_____

What do you want to work on in therapy?_____
_____
_____
_____
Have you ever been in therapy before? ☐ Yes ☐ No
When/for how long?_____
_____

Please note any medical problems:_____
_____
Please note treatment you have had for medical problems:_____
_____

Do you smoke? ☐ Yes ☐ No If yes, how much daily?_____
If yes, at what age did you start?_____
Do you drink alcohol? ☐ Yes ☐ No How much/how often?_____
When did you last drink alcohol?_____
Do you use non-prescription drugs? ☐ Yes ☐ No What?_____
_____
How often?_____ When last?_____
Do you consider drugs or alcohol a problem in your life? ☐ Yes ☐ No

How many meals do you eat per day?_____
How many hours per night do you sleep?_____
Is this normal for you? ☐ Yes ☐ No Do you wake rested? ☐ Yes ☐ No
Do you have frequent nightmares? Yes No

List any prescription medications you are currently taking and reasons for taking them:_____
_____
_____
_____
_____

Mother ☐ Living ☐ Deceased – when?_____
Father ☐ Living ☐ Deceased – when?_____
Do you have a step-parent?_____
Where do your parents live?_____
_____
Brothers and sisters? ☐ Yes ☐ No
Name Age Where do they live?
_____
_____
_____
Do you have a partner or spouse? ☐ Yes ☐ No
How many children do you have?_____
Do you have problems with ☐ Partner ☐ Child ☐ Parents ☐ Siblings
Were any of these your role(s) in your family? ☐ Caretaker ☐ Onlooker
☐ Babysitter ☐ Scapegoat ☐ Pleaser ☐ Isolate (withdrawn)
Other_____

Any violence in relationships? ☐ Yes ☐ Past ☐ Present ☐ No

Any physical abuse? ☐ Yes ☐ Past ☐ Present
☐ As an adult ☐ As a child
☐ No
Any sexual abuse? ☐ Yes ☐ Past ☐ Present
☐ As an adult ☐ As a child
☐ No

Any drug or alcohol abuse in your family? ☐ Yes ☐ No ☐ Parent ☐ Self
☐ Sibling ☐ Child ☐ Partner ☐ Other_____

Did you have learning difficulties in school? ☐ Yes ☐ No
Did you have discipline problems in school? ☐ Yes ☐ No
Last year of school completed:_____

Do you tend to have more problems or difficulties coping with life at certain times of the year?
☐ Yes ☐ No If yes, please describe the time of year and the nature of the problems:_____
_____
_____

Do you have trouble controlling your anger? ☐ Yes ☐ No

When angry, do you ever become verbally abusive? ☐ Yes ☐ Past ☐ Present ☐ No

When angry, do you every become physically abusive? ☐ Yes ☐ Past ☐ Present ☐ No

Have you ever attempted suicide? ☐ Yes ☐ No
If yes, when, how, and what happened?_____
_____
_____
_____
Have you thought about killing yourself in the past two weeks? ☐ Yes ☐ No
If yes, how did you plan to do it?_____
Did you make an attempt? ☐ Yes ☐ No
If yes, what happened?_____
_____
_____
_____
_____
Have you ever been hospitalized for psychiatric reasons? ☐ Yes ☐ No
Please indicate when, where, how long, and why for each stay:_____
_____
_____

Please feel free to add anything using the reverse side of this page.