PSYCHOTHERAPY, ADDICTION, TRAUMA RECOVERY
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Client Intake Form

Please fill in the information below and bring it with you to your first session. Leave blank any question you would rather not answer, or would prefer to discuss with your therapist. The confidentiality of all of the information you provide will be protected.

Personal Information

Name: _____ Date: _____

Parent/Legal Guardian (if under 18): _____

Address: _____

_____

Cell Phone: _____
May we leave a message?
☐ Yes
☐ No

Home Phone: _____
May we leave a message?
☐ Yes
☐ No

Email: _____
**Please note: Email correspondence is not considered to be a confidential medium of communication.*

DOB: _____ Age: _____ Gender: _____

Marital Status:
☐ Married
☐ Divorced
☐ Separated
☐ Never Married
☐ Domestic Partnership
☐ Widowed

Referred By (if any): _____

Emergency Contact: _____

Treatment History

Are you currently receiving psychiatric services, professional counseling or psychotherapy elsewhere?

☐ Yes
☐ No

Have you previously been engaged in psychotherapy?

☐ Yes, with (previous therapist name): _____
☐ No

Are you currently taking prescribed psychiatric medication (antidepressants or others)?

☐ If yes, please list: _____
☐ No

Prescribed by: _____

Health Information

Do you currently have a primary physician?

☐ If yes, who is it? _____
☐ No

Are you currently seeing more than one medical health specialist?

☐ No
☐ If yes, please list: _____

_____

When was your last physical? _____

Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, diabetes, etc.): _____

_____

Do you regularly use alcohol? ☐ No ☐ Yes

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

_____

Have you felt you ought to cut down on your drinking or drug use? ☐ Yes ☐ No

Have people annoyed you by criticizing your drinking or drug use? ☐ Yes ☐ No

Have you felt bad or guilty about your drinking or drug use? ☐ Yes ☐ No

Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover (eye-opener)? ☐ Yes ☐ No

Have you ever experienced any of the following?

Extreme anxiety	Yes / No
Panic attacks	Yes / No
Dramatic mood swings	Yes / No
Phobias	Yes / No
Extreme depressed mood	Yes / No
Hallucinations	Yes / No
Rapid speech	Yes / No
Eating disorder	Yes / No
Body image problems	Yes / No
Repetitive thoughts (e.g. obsessions)	Yes / No
Repetitive behaviors (e.g. frequent checking, handwashing)	Yes / No
Homicidal thoughts	Yes / No
Suicidal attempts	Yes / No If yes, when?

Occupational Information

Are you currently employed? ☐ Yes ☐ No

If yes, who is your current employer/position? _____

If yes, are you happy with your current position? _____

Please list any work related stressors, if any _____

_____

Family Mental Health History

Has anyone in your family (either immediate family members or relatives) experienced difficulties in the following? Please circle any that apply and list family member (e.g. parent, sibling, aunt, etc.)

Difficulty	Yes / No	Family Member
Depression	Yes / No	
Bipolar disorder	Yes / No	
Anxiety disorder	Yes / No	
Panic attacks	Yes / No	
Schizophrenia	Yes / No	
Alcohol abuse	Yes / No	
Substance abuse	Yes / No	
Eating disorders	Yes / No	
Learning disabilities	Yes / No	
Trauma history	Yes / No	
Suicide attempts	Yes / No	
Chronic illness	Yes / No	

Other Information

What brings you into therapy?

What are your goals for therapy?

How will you know you have achieved your goals?