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CLIENT INTAKE FORM

Please provide the following information for my records. Leave blank any question you would rather not answer, or would prefer to discuss in session. Information you provide here is held to the same standards of confidentiality as our therapy.

DEMOGRAPHIC INFORMATION

Full Name: _____ Date of Birth:_____

Home Address:_____

City: _____ Postal Code:_____

E-mail Contact:_____ Cell-phone:_____

Which pronoun do you use in reference to yourself: i.e. *she/her, he/him, they/them*

_____

TREATMENT HISTORY

Are you currently receiving psychiatric services, professional counseling or psychotherapy elsewhere? ( ) yes ( ) no

Have you had previous psychotherapy?

( ) no

( ) yes (provide any details you are comfortable giving at this time:

_____

_____

Are you currently taking prescribed psychiatric medication (antidepressants or others)? ( )yes ( )no

If yes, please list: _____

Prescribed by: _____

HEALTH AND SOCIAL INFORMATION

Do you currently have a primary physician? ( ) yes ( ) no

If yes, who is it? _____

Are you currently seeing more than one medical health specialist? ( ) yes ( ) no

If yes, please list: _____

When was your last physical? _____

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

_____

_____

Are you currently on medication to manage a physical health concern? If yes, please list:

_____

_____

Are you having any problems with your sleep habits? ( ) yes ( ) no

If yes, check where applicable:

( ) Sleeping too little ( ) Sleeping too much ( ) Poor quality sleep

( ) Disturbing dreams ( ) other _____

How many times per week do you exercise? _____

Estimate how long each time?_____

Are you having any difficulty with appetite or eating habits? ( ) no ( ) yes

If yes, check where applicable: ( ) Eating less ( ) Eating more ( ) Bingeing ( ) Restricting

Have you experienced significant weight change in the last 2 months? ( ) no ( ) yes

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? _____

How often do you engage in recreational drug use? ( ) daily ( ) weekly ( ) monthly ( ) rarely ( ) never

Do you smoke cigarettes or use other tobacco products? ( ) yes ( ) no

Have you had suicidal thoughts recently?

( ) frequently ( ) sometimes ( ) rarely ( ) never

Have you had them in the past?

( ) frequently ( ) sometimes ( ) rarely ( ) never

Are you currently in a romantic relationship? ( ) no ( ) yes

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

In the last year, have you experienced any significant life changes or stressors? If yes, please explain:

_____

_____

_____

Have you ever experienced any of the following?

Extreme depressed mood	Yes / No
Dramatic mood swings	Yes / No
Rapid speech	Yes / No
Extreme anxiety	Yes / No
Panic attacks	Yes / No
Phobias	Yes / No
Sleep disturbances	Yes / No
Hallucinations	Yes / No
Unexplained losses of time	Yes / No
Unexplained memory lapses	Yes / No
Alcohol/substance abuse	Yes / No
Frequent body complaints	Yes / No
Eating disorder	Yes / No
Body image problems	Yes / No
Repetitive thoughts (e.g. obsessions)	Yes / No
Repetitive behaviors (e.g. frequent checking, hand washing	Yes / No
Homicidal thoughts	Yes / No
Suicidal attempts	Yes / No If yes, when?

OCCUPATIONAL INFORMATION

Are you currently employed? ( ) no ( ) yes

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

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

Please list any work stressors_____

_____

RELIGIOUS/SPIRITUAL INFORMATION

Do you consider yourself to be religious? ( ) no ( ) yes

If yes, what is your faith? _____

If no, do you consider yourself to be spiritual? ( ) no ( ) yes

FAMILY MENTAL HEALTH HISTORY

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (circle any that apply and list family member, e.g. sibling parent, uncle, 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/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 (Please feel free to leave blank if you are unsure at present)

What do you consider to be your strengths?

_____

_____

_____

What do you like most about yourself?

_____

_____

What are effective coping strategies that you have learned?

_____

_____

_____

What are your goals for therapy?

_____

_____

_____

_____

_____