CLIENT INTAKE FORM

Client's Name: ____

Address: ____

____

Home Phone: ____________________ Work Phone: ____________________

Cell Phone: ____________________ Email: ____________________

Best way to reach you: ____

Health Plan: ____

Subscriber ID: ____________________DOB: ____________________

Name of Insured: ____________________DOB: ____________________

Co-pay: __________ # sessions per year: __________ Authorization #__________

Phone # for Providers: ____

Relationships Status: ____________________Children: ____________________

Current Living Situation (stressful/supportive): ______________________________

____

Education and Occupation: ____

____

1. Reason for seeking therapy. Current symptoms and stressors:

2. Goals for therapy:

3. Prior therapy experience (include prior any diagnosis you have been given):

4. Current medical status. Acute/chronic illness or disability:

5. Psychiatric medications and other medications:

• Previously

• Currently

6. Suicidal ideation (past and present) and hospitalizations:

7. Alcohol and drug use (past and present), frequency:

8. Sleep disturbance/nightmares:

9. Panic disorder/phobias:

10. Burning, cutting or other self-harm:

11. OCD or obsessive thinking:

12. History of abusive relationships:

13. History of process addictions (past and present), treatment:

____ workaholism

____ shopping

____ gambling

____ internet

____ gaming

____ love addiction

____ sex, porn addiction

____ eating disorder

____ other

14. Any legal proceedings pending or threatened? Any involvement with the criminal justice system or CPS?

15. Family History:

• Describe relationship with your Father:

• Describe relationship with your Mother:

• Describe relationship with siblings:

16. Current Family:

• Describe relationship with your husband/wife or partner:

• Describe relationships with your children, if applicable:

17. History of childhood trauma (include accidents, medical procedures, surgery, severe illness, abuse, neglect):

18.History of adult trauma (include major surgeries, accidents, domestic violence, crime, etc.):

19. History of grief/loss (include miscarriages, abortions, pet loss):

20. Please describe current diet (foods most commonly eaten):

List frequency of the following: (**1** - never / **2** - very rarely / **3** - once a week / **4** - several times per week / **5** - every day)

____ Diet soda

____ Other soda drinks

____ Sugar

____ Wheat

____ Dairy

____ Fast foods

____ Restaurant foods

____ Caffeine

____ Green vegetables

____ Water (amount per day) ____________________

____ Exercise

21. Current support system:

22. Please describe spirituality in your life (include practices and philosophy):