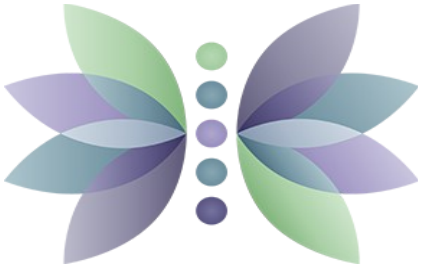

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Client Intake Form

Today's Date: _____

Legal Name: _____ Preferred Name: _____

Birth Date: _____ Age: _____

Gender: _____ Preferred Pronouns: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Cell Phone: _____ May I leave a message: YES NO
May I send a text? YES NO

Home Phone: _____ May I leave a message? YES NO

Email: _____ May I email you? YES NO

**Please note e-mail correspondence and texts are not guaranteed as a confidential method of communication. It is preferred that you use your secure client portal through Simple Practice.*

In case of emergency, I give permission to contact:

Name: _____ Relationship: _____

Telephone: (cell) _____ (home) _____ (work) _____

Referred by/how you found me: _____

If applicable, may I have permission to contact your referral source? YES NO

Are you currently being mandated to receive treatment? YES NO

Please briefly describe what brings you into counseling: _____

_____

_____

_____

Have you had or are you currently having thoughts about harming yourself or somebody else? YES NO

If yes, please describe: _____

_____

_____

Have you ever attempted suicide? YES NO

If yes, please describe: _____

_____

_____

Current marital status:

- ☐ Never married
- ☐ Married
- ☐ Cohabiting/Domestic Partnership
- ☐ Divorced/Separated
- ☐ Widowed
- ☐ Other _____

List any people with whom you are currently living, their ages, and their relationship to you:

1.) _____

2.) _____

3.) _____

4.) _____

Highest Level of Education:

_____ some high school _____ high school graduate _____ GED _____ technical/trade

_____ some college _____ college graduate _____ post-graduate _____ other

Please tell me about your work. What is your current occupation? Do you enjoy it? Is there anything stressful about your job? _____

_____

_____

_____

Have you previously received any type of mental health services (Therapy, psychiatric services, etc.)?

☐ No

☐ Yes, previous therapist/practitioner: _____

If yes, approximate time period: _____

Have you ever been hospitalized for a psychiatric issue? YES NO

If yes, please describe: _____

_____

_____

In the section below identify if there is a current or past history of any of the following or if you have been diagnosed as such:

Alcohol/Substance Use Disorder	YES	NO
Anxiety	YES	NO
Depression	YES	NO
Domestic Violence/Abuse	YES	NO
Eating Disorders	YES	NO
Schizophrenia	YES	NO
Suicide Attempts	YES	NO
Obsessive Compulsive Behavior/OCD	YES	NO
Borderline Personality Disorder	YES	NO
Bipolar Disorder	YES	NO
Others?	YES	NO

If yes, please list: _____

Has anyone in your family had these issues? YES NO

If yes, please describe: _____

_____

_____

Primary Care Physician: (name) _____ (phone) _____

Current *physical* health status (circle one): Excellent Good Fair Poor

Describe any current physical health concerns/illnesses: _____

_____

_____

Are you currently taking any prescribed medication? YES NO

Please list and explain for what reason: _____

_____

_____

When possible, I like to coordinate care with your physician, psychiatrist, or other health care provider. May I have your permission to communicate with your primary care doctor, psychiatrist, or other health care professional? YES NO

If yes, please initial here: _____ Name of provider: _____

Do you drink alcohol? YES NO

If yes, please describe type, amount and frequency: _____

_____

_____

Do you use recreational drugs? YES NO

If yes please describe type, amount and frequency: _____

_____

_____

How would you describe your uses of technology and/or online time and experiences? _____

_____

_____

Are you currently involved in a romantic relationship? YES NO

If yes, for how long? _____

On a scale of 1-10, how would you rate your satisfaction with your relationship? _____

Describe any issues in your current relationship: _____

_____

_____

Briefly describe any significant life changes or stressful events you have experienced recently: _____

_____

_____

Have you had or do you currently have any legal issues? YES NO

If yes, describe: _____

_____

Do you consider yourself to be spiritual or religious? YES NO

If yes, describe your faith or belief: _____

_____

_____

Symptom Checklist (check all that apply):

_____ I am dissatisfied with my life and want a change

_____ I am dissatisfied with the current state of my family life

_____ I am dissatisfied in my relationship with my spouse or significant other

_____ I am dissatisfied with, confused about or have questions regarding the sexual part of my life

_____ I am dissatisfied with my interpersonal relationships in general

_____ I am dissatisfied with my body

_____ In the past few months I have thought about how I could end my life

I have recently experienced:

_____ moodiness

_____ change I appetite (increase/decrease)

_____ racing thoughts

_____ difficulty sleeping/excessive sleep

_____ unusual anger or irritability

_____ change in sex drive

_____ stomach trouble/bowel disturbances

_____ mental confusion/disorientation

_____ loneliness

_____ inability to relax

_____ resentment

_____ decreased energy/motivation

_____ anxious feelings

_____ unusual fatigue/low energy

_____ nightmares

_____ feelings of hopelessness

_____ tearful or crying spells

_____ feelings of sadness or loss

_____ significant weight change (gain/loss)

_____ trouble concentrating

In the last few weeks/months, I have done the following to cope with my problems:

_____ worked more than usual

_____ binge eating

_____ drank alcohol

_____ used illegal drugs

_____ refused to get out of bed

_____ neglected my hygiene

_____ isolated myself from other people

_____ misused prescription drugs

_____ harmed myself by cutting, burning, etc.

_____ used pornography

_____ ignored my responsibilities

_____ acted sexual in an unusual way for me

In my lifetime, I have experienced:

_____ the loss of a loved one

_____ an abortion

_____ a miscarriage/stillbirth

_____ the death of a child (following birth)

_____ a traumatic event

_____ divorce of my parents

_____ divorce of my own

_____ bullying

_____ abandonment by loved ones

_____ sexual abuse or assault

_____ the death of a pet

_____ feeling unloved by important people

_____ being fired from a job

_____ an addictive habit

_____ mental, verbal, or physical abuse

_____ the loss of someone by suicide

_____ something else significant to me: _____

What do you hope to accomplish by coming to therapy? _____

Is there anything else you would like me to know? _____

Client Name (Please Print)	Client Signature	Date