CLIENT INTAKE FORM

Please note that the content of this form is personal in nature and could be difficult for some. If you feel uncomfortable completing sections of this form, please leave the section blank and proceed to the next section.

Full Name: _____ Date of Birth: _____

Home Address: _____ Cell Phone: _____

City: _____ Zip Code:_____

Email Address: _____

Emergency Contact: _____ Phone: _____

Please tell us the pronoun/s that you use in reference to yourself. *For example, she/her, he/him, they/them.*

_____

Insurance Co Name: _____

Member Number: _____ Group Number:_____

CONCERN/S

What are the concerns that brought you to counseling? _____

_____

_____

How long have you been having these concerns? _____

_____

MENTAL HEALTH HISTORY

Have you been in therapy previously? ☐ No ☐ Yes If yes, on _____ occasions.

Longest treatment by: _____ for _____
Provider Name Condition

sessions from _____/_____ to _____/_____
Month/Year Month/Year

Has any family member ever received counseling or psychotherapy? ☐ No ☐ Yes

Have you received prior inpatient treatment for psychiatric or substance use disorder? ☐ No ☐ Yes

Longest treatment by: _____ for _____
Facility Name Condition

from _____/_____ to _____/_____
Month/Year Month/Year

Has any family member received inpatient treatment for a mental health condition? ☐ No ☐ Yes

Have you ever taken or are you current prescribed any psychotropic medication? ☐ No ☐ Yes

Past Mental Health Diagnosis/es: _____

_____

_____

FAMILY HISTORY

FAMILY OF ORIGIN

Describe your parents:

Full Name:	_____	_____
Occupation:	_____	_____
Education:	_____	_____
Health Status:	_____	_____
Deceased?	☐ No ☐ Yes	☐ No ☐ Yes
If so, your age at their time of death:	_____	_____

Present during childhood:

	NA	Present Entire Childhood	Present Part of Childhood	Not Present
Mother	☐	☐	☐	☐
Father	☐	☐	☐	☐
Other Parent	☐	☐	☐	☐
Step Mother	☐	☐	☐	☐
Step Father	☐	☐	☐	☐
Sibling(s)	☐	☐	☐	☐
Other	☐	☐	☐	☐

Parent's Martial Status:

☐ Married to each other
☐ Separated for _____ years
☐ Divorced for _____ years
☐ Parent(s) remarried
☐ Married to each other

Describe childhood family experience:

☐ outstanding home environment
☐ normal home environment
☐ chaotic home environment
☐ witnessed physical/verbal/sexual abuse toward others
☐ experienced physical/verbal/sexual abuse from others

Special circumstances in childhood: _____

_____

_____

IMMEDIATE FAMILY:

Relationship Status:

☐ single, never married
☐ engaged _____ years
☐ married _____ years
☐ divorced _____ years
☐ separated _____ years
☐ divorce in process
☐ partner for _____ years
☐ _____ prior marriages

Intimate Relationship Status:

☐ never been in a serious relationship
☐ not currently in a relationship
☐ currently in a serious relationship

Relationship Satisfaction:

☐ very satisfied with relationship
☐ satisfied with relationship
☐ dissatisfied with relationship
☐ Other _____

Children:

☐ currently pregnant?
Number of pregnancies _____
Children and date(s) of birth (DOB), if applicable:

_____

_____

_____

_____

_____

SEXUAL ORIENTATION:

☐ heterosexual orientation
☐ homosexual orientation
☐ bisexual orientation
☐ currently sexually active
☐ currently sexually satisfied
☐ currently sexually dissatisfied
☐ other orientation:

_____

Describe any past or current significant issues in intimate relationships:

_____

_____

_____

Describe any past or current significant issues in other immediate family relationships: _____

_____

_____

LIVING ARRANGEMENT: Who do you currently live with?

Name	Age	Relationship to You
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

EMPLOYMENT/EDUCATION

EMPLOYMENT:

☐ full-time ☐ unemployed
☐ part-time ☐ disabled
☐ student ☐ retired

Current workplace: _____

How long at this place of employment? _____

Longest place of employment: _____

How long at this place of employment? _____

Level of Education:

☐ less than high school level
☐ high school or equivalent
☐ associate's degree
☐ some college with no degree
☐ college degree
☐ post graduate education

SUBSTANCE USE

Have You tried or used any of the following?

	Tried?	Used Regularly?	Currently Use?		Tried?	Used Regularly?	Currently Use?
Alcohol	☐	☐	☐	Pain Killers	☐	☐	☐
Marijuana	☐	☐	☐	Heroin	☐	☐	☐
Tobacco	☐	☐	☐	Ecstacy	☐	☐	☐
Cocaine	☐	☐	☐	Hallucinogens	☐	☐	☐
Inhalants	☐	☐	☐	Stimulants	☐	☐	☐

Have you been in treatment for substance use/abuse? ☐ Yes ☐ No

LEGAL, MILITARY, FINANCIAL

Legal Problems? ☐ Yes ☐ No

Military Service? ☐ Yes ☐ No

Financial Problems? ☐ Yes ☐ No

MEDICAL HISTORY

Primary Care Physician: _____ Phone: _____

Clinic: _____

Psychiatrist (if applicable): _____ Phone: _____

Clinic: _____

Health Condition/s: _____

_____

_____

_____

Describe your exercise pattern/s: _____

_____

_____

_____

Have you experienced any serious hospitalizations and/or accidents? If so, please describe:

_____

_____

_____

_____

Please list your medications (if any), list dosage and condition the medication treats:

_____

_____

_____

_____

NUTRITION

Are you satisfied with your eating patterns? ☐ Yes ☐ No

Do you ever eat in secret? ☐ Yes ☐ No

Does your weight affect the way you feel about yourself? ☐ Yes ☐ No

Have any members of your family suffered with an eating disorder? ☐ Yes ☐ No

Do you currently suffer with or have you ever suffered in the past with an eating disorder? ☐ Yes ☐ No

HOBBIES, RECREATION, CULTURAL CONSIDERATIONS

What activities/hobbies do you enjoy?_____

_____

_____

What cultural or religious considerations are important to discuss with your therapist?_____

_____

_____

Name: _____ Date: _____

In the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly everyday
Feeling nervous, anxious or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Worrying too much about different things	0	1	2	3
Trouble relaxing	0	1	2	3
Being so restless that it is hard to sit still	0	1	2	3
Becoming easily annoyed or irritable	0	1	2	3
Feeling afraid as if something awful might happen	0	1	2	3

	Not at all	Several days	More than half the days	Nearly everyday
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed or hopeless	0	1	2	3
Trouble falling or staying asleep, or sleeping too much	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
Trouble concentrating on things, such as reading or watching shows	0	1	2	3
Moving or speaking so slowly that others notice. Or, the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
Thoughts that you would be better off dead or hurting yourself in some way	0	1	2	3

When thinking about drug use, include drug use and the use of prescription drugs other than prescribed:

Have you ever felt that 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 ever 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?	Yes	No

MMAS-4: If you take medications to manage your mental or physical health:

Do you ever forget to take your medicine?	Yes	No
Are you careless at times about taking your medicine?	Yes	No
Sometimes if you feel worse when you take the medicine, do you stop taking it?	Yes	No
When you feel better do you sometimes stop taking your medicine?	Yes	No

DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Adult

Name: _____ Age: ____ Sex: ❑ Male ❑ Female Date:_____

If this questionnaire is completed by an informant, **what is your relationship with the individual? _____**
In a typical week, approximately how much time do you spend with the individual? _____ hours/week

Instructions: The questions below ask about things that might have bothered you. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem during the **past TWO (2) WEEKS**.

	During the past **TWO (2) WEEKS**, how much (or how often) have you been bothered by the following problems?	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
I.	1. Little interest or pleasure in doing things?	0	1	2	3	4	
	2. Feeling down, depressed, or hopeless?	0	1	2	3	4	
II.	3. Feeling more irritated, grouchy, or angry than usual?	0	1	2	3	4	
III.	4. Sleeping less than usual, but still have a lot of energy?	0	1	2	3	4	
	5. Starting lots more projects than usual or doing more risky things than usual?	0	1	2	3	4	
IV.	6. Feeling nervous, anxious, frightened, worried, or on edge?	0	1	2	3	4	
	7. Feeling panic or being frightened?	0	1	2	3	4	
	8. Avoiding situations that make you anxious?	0	1	2	3	4	
V.	9. Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)?	0	1	2	3	4	
	10. Feeling that your illnesses are not being taken seriously enough?	0	1	2	3	4	
VI.	11. Thoughts of actually hurting yourself?	0	1	2	3	4	
VII.	12. Hearing things other people couldn't hear, such as voices even when no one was around?	0	1	2	3	4	
	13. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	0	1	2	3	4	
VIII.	14. Problems with sleep that affected your sleep quality over all?	0	1	2	3	4	
IX.	15. Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?	0	1	2	3	4	
X.	16. Unpleasant thoughts, urges, or images that repeatedly enter your mind?	0	1	2	3	4	
	17. Feeling driven to perform certain behaviors or mental acts over and over again?	0	1	2	3	4	
XI.	18. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	0	1	2	3	4	
XII.	19. Not knowing who you really are or what you want out of life?	0	1	2	3	4	
	20. Not feeling close to other people or enjoying your relationships with them?	0	1	2	3	4	
XIII.	21. Drinking at least 4 drinks of any kind of alcohol in a single day?	0	1	2	3	4	
	22. Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco?	0	1	2	3	4	
	23. Using any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed [e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)]?	0	1	2	3	4	