

INDIVIDUAL INTAKE FORM

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Date: _____

Client Last Name:	Email Address
First Name:	Birthdate: _____ Age: _____
Address:	Legal Guardian Name: (if under 18)
City: _____ Zip: _____	
Education:	Gender: _____ M/F
Profession:	Home Phone: _____
Marital Status: _____ M/ S/D/W	Cell Phone: _____
Children: Y/N If yes, how old?	Emergency Contact: _____
Referred By: _____	Emergency Phone: _____
	Relationship to Client: _____

Presenting Problem/Concern:

Suicidality and Violence Assessment:
Suicidal History (date/method of attempts): _____

Current Risk for Suicide: () None () Low () Medium () High
 Current Risk for Violence/Dangerousness ()None ()Low ()Medium ()High

General and Mental Health Information

How would you rate your current physical health?

Please list any specific health problems you are currently experiencing:

Poor Unsatisfactory Satisfactory Good Very good

How would you rate your current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:

Are you currently taking any prescription medications?

Medications	Dosage	Reason
1.		
2.		
3.		
4.		
Hospitalizations/Surgery		

How many times per week do you generally exercise? _____

What types of exercise to you participate in:

Please list any difficulties you experience with your appetite or eating patterns

Do you binge/purge?. Yes No

If so, how often? _____

Are you currently experiencing overwhelming sadness, grief or depression?

No Yes

If yes, for approximately how long? _____

Are you currently experiencing anxiety, panic attacks or have any phobias?

No Yes

If yes, when did you begin experiencing this?

Are you currently experiencing any chronic pain?

No Yes

If yes, please describe? _____

Do you drink alcohol more than once a week? No Yes

If yes, how often? _____

How often do you engage in recreational drug use?

Daily Weekly Monthly Infrequently Never

Please list any prescription and/or illegal drugs you are PRESENTLY taking that have not been prescribed by a doctor:

Please list any prescription and/or illegal drugs you have taken in the PAST that have not been prescribed by a doctor:

Family Mental Health History:

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, mother, sister, grandmother, uncle, etc.).

Alcohol/Substance Abuse: No Yes _____

Anxiety: No Yes _____

Depression: No Yes _____

Domestic Violence: No Yes _____

Eating Disorders: No Yes _____

Obesity: No Yes _____

Obsessive Compulsive Behavior: No Yes _____

Schizophrenia: No Yes _____

Suicide Attempts: No Yes _____

Family Background:

Parents still living? Father ()Yes ()No Mother: ()Yes ()No

Parents: ()Married ()Separated ()Divorced ()Never Married

Siblings (Names/Ages): _____

ADDITIONAL INFORMATION:

With whom are you living?

Have you been married before?

Are you currently in a romantic relationship? No Yes

If yes, for how long?

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

What significant life changes or stressful events have you experienced recently?

Explain if any

Are you currently employed? No Yes

If yes, what is your current employment situation:

Do you enjoy your work? Is there anything stressful about your current work?

Do you consider yourself to be spiritual or religious? No Yes

If yes, describe your faith or belief:

Previous Therapy Experiences:

Reason (s): _____

Therapy Expectations:

What are you expecting to get from therapy? _____

Do you have any particular goals that you would like to see met in therapy?

Please Explain: _____