

Intake Form

Client Name: _____ Age: __ DOB: _____ Date : _____

Identifying Information/Current Living Situation: (Who do you live with?): _____

Presenting Problem: (What brought you to this session today? How long has the problem been going on?)

Current Symptoms: (Check all that apply):

<input type="checkbox"/> Mood Fluctuations	<input type="checkbox"/> Suicidal Thoughts/Gestures
<input type="checkbox"/> Anger and/or Irritability	<input type="checkbox"/> Family/Marital/Couples Conflict
<input type="checkbox"/> Fear and/or Anxiety	<input type="checkbox"/> Identity Confusion
<input type="checkbox"/> Obsessions and/or Compulsions	<input type="checkbox"/> Hyperactivity
<input type="checkbox"/> Depression and/or Sadness	<input type="checkbox"/> Social Anxiety
<input type="checkbox"/> Harm to Self or Others	<input type="checkbox"/> Weight and/or Body Image Issues
<input type="checkbox"/> Low Self-esteem	<input type="checkbox"/> Eating Disorder or Disordered Eating
<input type="checkbox"/> Grief/Loss	<input type="checkbox"/> Spiritual Distress
<input type="checkbox"/> Attention Deficits	<input type="checkbox"/> Pre-Marital or Marital Therapy
<input type="checkbox"/> Sleep Difficulties	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Helplessness and/or Hopelessness	<input type="checkbox"/> Other: _____

Substance Use/Abuse: (What is your past/current substance use?): _____

Mental Health History: (Did you have any counseling before? If so, describe. Have you ever taken any psychotropic medication?): _____

Stressors: (What kinds of things in your life cause you to worry?): _____

Developmental and Medical History: (Any significant events from childhood or at present?)

Nutrition and Exercise:

Physician and/or Psychiatric Providers: (When was your last appointment?)

Family of Origin and Current Nuclear Family:

Member	Name	Occupation	Age	Relationship
Birth Mother				
Birth Father				
Stepmother				
Stepfather				
Siblings				
Spouse/Sig. Other				
Children				

Current Family Dynamic:

Current Family Mental Health and Medical History:

Family of Origin Issues: (What was your birth family like?)

Educational and Employment History:

Social Functioning: (Sexual and social history):

Trauma and/or Abuse: (Have you experienced anything that you consider to be traumatic or abusive?)

Recreation and Pleasurable Activities:

Spiritual and/or Religious History:

Self-perceived Strengths and Weaknesses:

Cultural or Ethnic Influences: (Are there any cultural or ethnic factors that effect your life?)

Suicide, Homicide, Self-harm History and Present Functioning:

Legal Issues, including any current or pending criminal charges?

Preliminary Therapeutic Goals: (List 3 or 4 things you want to accomplish through therapy?)

Is There Anything Else You Want to Report?
