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CLIENT INTAKE & ASSESSMENT FORM

Please provide the following information, and answer the questions below. Please note: Information you provide here is protected as confidential information.

Please fill out this form, and bring it to your next session.

Name:

_____
(Last) (First) (Middle Initial)

Name of parent/guardian (if under 18 years):

_____
(Last) (First) (Middle Initial)

Birth Date: _____ /_____ /_____ Age: _____ Gender: _____

Sexual Orientation: _____

Marital Status:

□ Never Married □ Domestic Partnership □ Married □ Separated □ Divorced □ Widowed

Please list any children/age: _____

Address:

_____
(Street and Number)

_____
(City) (State) (Zip)

Preferred Phone: _____ May I leave a message? □ Yes □ No

Other Phone: _____ May I leave a message? □ Yes □ No

E-mail: _____ May I email you? □ Yes □ No

*Please note: Email correspondence is not considered to be a confidential medium of communication.

Referred by (if any): _____

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

□ No □ Yes, previous therapist/practitioner:

_____

Are you currently taking any prescription medication? □ Yes □ No

Please list, and describe their use:

_____

_____

Have you ever been prescribed psychiatric medication? □ Yes □ No

Please list and provide dates:

_____

_____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:

_____

2. 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:

_____

3. How many times per week do you generally exercise? _____

What types of exercise to you participate in _____

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

_____

5. Are you currently experiencing overwhelming sadness, grief or depression? □ No □ Yes

If yes, for approximately how long? _____

6. Are you currently experiencing anxiety, panic attacks or have any phobias? □ No □ Yes

If yes, when did you begin experiencing this? _____

7. Have you ever had any serious thoughts of suicide or homicide? □ No □ Yes

8. Have you ever attempted suicide or homicide? □ No □ Yes

9. Do you currently feel suicidal or homicidal? □ No □ Yes

10. Have you experienced physical and/or sexual abuse? □ No □ Yes

If yes, by whom? _____ When?_____

11. Are you currently experiencing any chronic pain? □ No □ Yes

If yes, please describe _____

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

13. How often do you engage recreational drug use?

□ Daily □ Weekly □ Monthly □ Infrequently □ Never

14. Do you feel as though you have an effective social support system? □ No □ Yes

Please describe: _____

15. 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 satisfaction with the relationship? _____

16. What significant life changes or stressful events have you experienced recently:

FAMILY MENTAL HEALTH HISTORY:

Place of Birth: _____

Ethnic Background: _____

Are you adopted? □ No □ Yes

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, grandmother, uncle, etc.).

	Please Circle	List Family Member
Alcohol/Substance Abuse	yes/no	
Anxiety or Depression	yes/no	
Domestic Violence	yes/no	
Eating Disorders	yes/no	
Obesity	yes/no	
Obsessive Compulsive Behavior	yes/no	
Schizophrenia	yes/no	
Suicide Attempts	yes/no	
Completed Suicide	yes/no	
Homicide	yes/no	

ADDITIONAL INFORMATION:

1. Are you currently employed/enrolled in school? □ No □ Yes

If yes, what is your current employment/education situation:

_____

Do you enjoy your work/school? □ No □ Yes

Is there anything stressful about your current work/school?

_____

_____

What is your highest degree of education?

□ High School □ G.E.D □ College Degree □ Advanced Degree

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

If yes, describe your faith or belief:

_____

3. What do you consider to be some of your strengths?

4. What do you consider to be some of your coping skills?

5. What do you consider to be some of your weaknesses?

6. What would you like to accomplish out of your time in therapy?