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Intake Form

Client Information

Client Name:_____ Date:_____

Name (if different than client):_____Referred by:_____

Address:_____ Gender: M / F / other:_____

City: _____ State: _____ Zip Code: _____Date of Birth:_____

(H): _____ (W):_____(C):_____

Email address 1:_____ Email address 2:_____

Confidential messages be left on (please circle all that apply): Cell phone Work phone Email 1 Email 2

Emergency Contact Person: _____Phone:_____

Email address:_____Relationship to you:_____

Primary Care Physician:_____Phone:_____

Address:_____City:_____State:_____Zip:_____

Type of Service Requested: (please circle all that apply): Individual Couples Family Teen Neurofeedback

Relationship Status (please circle one):

Single Separated
Married Widowed
Divorced Other_____

Racial Identity (please circle all that apply):

Asian/Asian American White/European American
Black/African-American Prefer not to specify
Hispanic/Latino Other _____

Presenting Problems and Concerns

Please list the major issues you would like help with and rate their severity (according to the scale below):

1----------2----------3----------4----------5----------6----------7----------8----------9 ----------10
Not a Problem Mild Problem Moderate Problem Severe Problem Couldn't be Worse **RATING**

1._____ _____

2._____ _____

3._____ _____

Briefly describe what motivated you to seek therapy at this time in particular:_____

_____

_____

Briefly describe previous/current methods of coping:_____

_____

Please check all of the behaviors and symptoms that you consider problematic:

- ☐ Distractibility
- ☐ Hyperactivity
- ☐ Impulsivity
- ☐ Boredom
- ☐ Poor memory/confusion
- ☐ Seasonal mood changes
- ☐ Sadness/depression
- ☐ Loss of pleasure/interest
- ☐ Hopelessness
- ☐ Thoughts of death
- ☐ Self-harm behaviors
- ☐ Crying spells
- ☐ Loneliness
- ☐ Low self worth
- ☐ Guilt/shame
- ☐ Fatigue
- ☐ Other:_____
- ☐ Change in appetite
- ☐ Lack of motivation
- ☐ Withdrawal from people
- ☐ Anxiety/worry
- ☐ Panic attacks
- ☐ Fear away from home
- ☐ Social discomfort
- ☐ Obsessive thoughts
- ☐ Compulsive behavior
- ☐ Aggression/fights
- ☐ Frequent arguments
- ☐ Irritability/anger
- ☐ Homicidal thoughts
- ☐ Flashbacks
- ☐ Hearing voices
- ☐ Visual hallucinations
- ☐ Suspicion/paranoia
- ☐ Racing thoughts
- ☐ Excessive energy
- ☐ Wide mood swings
- ☐ Sleep problems
- ☐ Nightmares
- ☐ Eating problems
- ☐ Gambling problems
- ☐ Computer addiction
- ☐ Problems with pornography
- ☐ Parenting problems
- ☐ Sexual problems
- ☐ Relationship problems
- ☐ Work/school problems
- ☐ Alcohol/drug use
- ☐ Recurring, disturbing memories

Are your problems affecting any of the following?

- ☐ Handling everyday tasks
- ☐ Work/School
- ☐ Recreational activities
- ☐ Self esteem
- ☐ Housing
- ☐ Sexual activity
- ☐ Relationships
- ☐ Legal matters
- ☐ Health
- ☐ Hygiene
- ☐ Finances

☐ Yes ☐ No Have you ever had thoughts, made statements, or attempted to hurt yourself? If yes, please describe:_____

☐ Yes ☐ No Have you ever had thoughts, made statements, or attempted to hurt someone else? If yes, please describe:_____

☐ Yes ☐ No Have you recently been physically hurt or threatened by someone else? If yes, please describe:_____

Please check if you have experienced any of the following types of trauma or loss:

- ☐ Emotional abuse
- ☐ Sexual abuse
- ☐ Physical abuse
- ☐ Parent substance abuse
- ☐ Teen pregnancy
- ☐ Neglect
- ☐ Violence in the home
- ☐ Crime victim
- ☐ Parent illness
- ☐ Placed a child for adoption
- ☐ Lived in a foster home
- ☐ Multiple family moves
- ☐ Homelessness
- ☐ Loss of a loved one
- ☐ Financial problems

Date of last physical exam: _____

Have you experienced any of the following medical conditions during your lifetime?

- ☐ Allergies
- ☐ Chronic pain
- ☐ Dizziness/fainting
- ☐ High fevers
- ☐ Sexually transmitted disease
- ☐ Asthma
- ☐ Surgery
- ☐ Meningitis
- ☐ Diabetes
- ☐ Abortion
- ☐ Headaches
- ☐ Serious accident
- ☐ Seizures
- ☐ Hearing problems
- ☐ Sleep disorder
- ☐ Stomach aches
- ☐ Head injury
- ☐ Vision problems
- ☐ Miscarriage
- ☐ Other: _____

Please list any CURRENT health concerns: _____

Current prescription medications: ☐ None

Medication	Dosage	Date First Prescribed	Prescribed By

Who is your primary care physician? Name & phone number: _____

_____

Have you seen a mental health professional before? If so, please describe dates, reason, experience:_____

_____

_____

Have you ever been hospitalized for a psychiatric issue? If so, please describe where, when, and why:_____

_____

Do you use recreational drugs? If so, please describe the type, amount, and frequency:_____

_____

Do you drink alcohol? If so, please describe the type, amount, and frequency:_____

_____

Have use of drugs or alcohol ever caused significant social or occupational difficulties? If so, please describe:

_____

Please describe your current living situation (i.e. live alone, live with others, etc):_____

_____

What is your current occupation and length of time in position?_____

_____

What is your highest level of education?_____

Family History

Is there a history of mental illness in your family? If so, please describe:_____

_____

_____

What are your goals for therapy?_____

_____

_____

What else would you like me to know?_____

_____

_____

How will you know if/when treatment has been effective?_____

_____

_____

_____