

Client Intake Form

Thank you for taking the time to openly and honestly answer the questions below. Your genuine responses are appreciated, as all information provided will assist your therapist to better understand your presenting issues and need for treatment. If there are any questions you do not feel comfortable answering at this point in time, please indicate this on the particular section of the form. Thank you.

Name: _____ Date: _____

Briefly describe the reason(s) you are seeking psychotherapy at this time:

Current symptom checklist:

Please indicate the severity of each current symptom by checking the appropriate box.

Never = I have never experienced this symptom

Past = I am currently not experiencing this symptom, but have in the past

Mild = Mildly impacts quality of life, but no significant impairment of day-to-day functioning.

Moderate = Significantly impacts quality of life and/or day-to-day functioning.

Severe = Profoundly impacts quality of life and/or day-to-day functioning.

Symptom	Never	Past	Mild	Moderate	Severe
Depressed mood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Suicidal thoughts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Self-harm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Appetite disturbance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep disturbance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue/low energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poor concentration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Worthlessness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Guilt/shame	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hopelessness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Social Isolation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mood swings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Elevated mood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anger/Irritability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aggressive behaviors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Relationship difficulties	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Symptom	Never	Past	Mild	Moderate	Severe
Hyperactivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety/worry/fear	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Panic attacks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Phobias	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Obsessive thoughts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Compulsive behaviors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Delusions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hallucinations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dissociation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anorexia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Binge Eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Purging/vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Laxative/diuretic use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Substance use/abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexual dysfunction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Grief	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Past Psychiatric History:

Question	No	Yes
Are you currently being prescribed psychiatric medication(s)?	<input type="checkbox"/>	<input type="checkbox"/>
<i>If yes, please specify medication(s) being prescribed and by whom:</i>		
Have you been prescribed psychiatric medication(s) in the past?	<input type="checkbox"/>	<input type="checkbox"/>
<i>If yes, please specify date(s), medication(s) prescribed and by whom:</i>		
Have you ever been seen at an ER for psychiatric reasons or admitted to a psychiatric inpatient facility?	<input type="checkbox"/>	<input type="checkbox"/>
<i>If yes, please specify dates, duration of treatment, locations treated and reason for treatment:</i>		
Have you ever received outpatient mental health/counseling services?	<input type="checkbox"/>	<input type="checkbox"/>
<i>If yes, please specify date(s), treatment facility, duration of treatment and reason for treatment:</i>		
Have you ever attempted suicide?	<input type="checkbox"/>	<input type="checkbox"/>
<i>If yes, please specify number of attempts, approximate date or age at attempt and method:</i>		
Have you ever intentionally harmed yourself, such as cutting, burning, bruising or other methods?	<input type="checkbox"/>	<input type="checkbox"/>
<i>If yes, please specify age when this behavior first began, type of self-harm behavior and frequency of behavior:</i>		
<i>If yes, do you currently engage in self-harming behavior?</i>	<input type="checkbox"/>	<input type="checkbox"/>
<i>If no, when was the last episode of self-harming behavior:</i>		
Have you ever intentionally harmed someone else, such as physical fights, assaults, etc?	<input type="checkbox"/>	<input type="checkbox"/>
<i>If yes, please specify who, frequency, method of harm and outcome:</i>		

Medical History:

Question	No	Yes
How would you describe your current overall physical health? <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor		
Do you have any current medical conditions, chronic illness or physical complaints, such as asthma, hypertension, diabetes, seizure disorder, thyroid problems, fibromyalgia, cancer, etc?	<input type="checkbox"/>	<input type="checkbox"/>
<i>If yes, please specify:</i>		
Have you had any past serious medical conditions, surgeries or accidents?	<input type="checkbox"/>	<input type="checkbox"/>
<i>If yes, please specify:</i>		
Do you have a primary care physician?	<input type="checkbox"/>	<input type="checkbox"/>
<i>If yes, please specify name and location:</i>		
Are you currently being prescribed medical medication(s)?	<input type="checkbox"/>	<input type="checkbox"/>
<i>If yes, please specify:</i>		

Developmental History:

Question	No	Yes
To your knowledge, did your mother have any complications during pregnancy or labor and delivery?	<input type="checkbox"/>	<input type="checkbox"/>
<i>If yes, please specify:</i>		
To your knowledge, did you reach all of your developmental milestones (i.e. walking, talking) within the normal range?	<input type="checkbox"/>	<input type="checkbox"/>
<i>If yes, please specify:</i>		
Are you adopted?	<input type="checkbox"/>	<input type="checkbox"/>
<i>If yes, at what age?</i>		
Did you experience any trauma or significant loss (i.e. the death of a parent, instability with caregivers) during your early childhood?	<input type="checkbox"/>	<input type="checkbox"/>
<i>If yes, please specify:</i>		

Family History:

Question	No	Yes
Do you have a family history of any of the following: <i>(if yes, please specify whom and provide brief details)</i>		
Chronic or serious medical conditions	<input type="checkbox"/>	<input type="checkbox"/>
Mental health issues	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol abuse	<input type="checkbox"/>	<input type="checkbox"/>
Drug abuse	<input type="checkbox"/>	<input type="checkbox"/>

Relationship History:

Question	No	Yes
Are you currently married or involved in a significant intimate relationship?	<input type="checkbox"/>	<input type="checkbox"/>
<i>If yes, for how long:</i>		
Please briefly describe any significant past relationships:		

Trauma History:

Question	No	Yes								
Have you witnessed or experienced any past or current trauma, such as childhood abuse or domestic violence?	<input type="checkbox"/>	<input type="checkbox"/>								
<p><i>If yes, check all that apply:</i></p> <table border="0"> <tr> <td><input type="checkbox"/> Childhood sexual abuse</td> <td><input type="checkbox"/> Childhood physical abuse</td> </tr> <tr> <td><input type="checkbox"/> Childhood emotional abuse and/or neglect</td> <td><input type="checkbox"/> Witness of domestic violence</td> </tr> <tr> <td><input type="checkbox"/> Victim of domestic violence</td> <td><input type="checkbox"/> Sexual assault/rape during adolescence/adulthood</td> </tr> <tr> <td><input type="checkbox"/> Physical assault during adolescence/adulthood</td> <td></td> </tr> </table>			<input type="checkbox"/> Childhood sexual abuse	<input type="checkbox"/> Childhood physical abuse	<input type="checkbox"/> Childhood emotional abuse and/or neglect	<input type="checkbox"/> Witness of domestic violence	<input type="checkbox"/> Victim of domestic violence	<input type="checkbox"/> Sexual assault/rape during adolescence/adulthood	<input type="checkbox"/> Physical assault during adolescence/adulthood	
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<input type="checkbox"/> Victim of domestic violence	<input type="checkbox"/> Sexual assault/rape during adolescence/adulthood									
<input type="checkbox"/> Physical assault during adolescence/adulthood										

Substance Use History:

Question	No	Yes
Do you currently use alcohol?	<input type="checkbox"/>	<input type="checkbox"/>
<i>If yes, please specify age of first use, type, frequency and amount:</i>		
Do you currently use tobacco?	<input type="checkbox"/>	<input type="checkbox"/>
<i>If yes, please specify age of first use, type, frequency and amount:</i>		
Do you currently use drugs, such as marijuana, cocaine, or methamphetamine?	<input type="checkbox"/>	<input type="checkbox"/>
<i>If yes, please specify type, age of first use, frequency and amount:</i>		
Do you have a past history of alcohol or drug misuse/abuse/dependence?	<input type="checkbox"/>	<input type="checkbox"/>
<i>If yes, please provide details:</i>		
Have you experienced any legal problems due to alcohol and/or drug use, such as DUI?	<input type="checkbox"/>	<input type="checkbox"/>
<i>If yes, please specify the type of legal problems experienced:</i>		
Have you experienced any other negative consequences from alcohol and/or drug use, such as fights, blackouts, seizures, or withdrawal symptoms?	<input type="checkbox"/>	<input type="checkbox"/>
<i>If yes, please provide details:</i>		
Do you have current involvement, or past experience, with substance abuse treatment, such as detox, rehabilitation programs or 12-step groups?	<input type="checkbox"/>	<input type="checkbox"/>
<i>If yes, please provide details:</i>		

Educational History:

Question	No	Yes
Are you currently enrolled in school?	<input type="checkbox"/>	<input type="checkbox"/>
<i>If yes, where and for what:</i>		
What is your highest educational level?		

Vocational History:

Question	No	Yes
Are you currently employed outside of the home?	<input type="checkbox"/>	<input type="checkbox"/>
<i>If yes, please list current occupation/employer?</i>		
<i>How long have you been in this position?</i>		
Are you satisfied with your current employment?	<input type="checkbox"/>	<input type="checkbox"/>
Please indicate any past pertinent vocational history:		

Legal History:

Question	No	Yes
Are you currently involved in the judicial system, such as being on probation?	<input type="checkbox"/>	<input type="checkbox"/>
<i>If yes, please provide details:</i>		
Do you have any past legal history, such as being arrested, convicted of a crime or incarcerated?	<input type="checkbox"/>	<input type="checkbox"/>
<i>If yes, please provide details:</i>		

Military History:

Question	No	Yes
Are you currently involved with the military?	<input type="checkbox"/>	<input type="checkbox"/>
<i>If yes, please provide details:</i>		
Do you have past military involvement?	<input type="checkbox"/>	<input type="checkbox"/>
<i>If yes, please provide details:</i>		

Cultural History:

Question	No	Yes
Please describe your sexual orientation (i.e. heterosexual, homosexual, bisexual, transgendered, etc):		
Please describe your ethnic and/or cultural background:		
Do you identify with any particular spiritual or religious affiliation?	<input type="checkbox"/>	<input type="checkbox"/>
<i>If yes, please describe:</i>		

Please describe skills, resources and/or strengths you feel you possess:

Please indicate what goals you would like to accomplish by seeking therapy at this time, or in other words, what are you hoping to gain by seeking therapy at this time?

Is there anything else important about yourself or your current situation that you would like for me to know at this time?

Thank you for your time and attention in completing this intake form. I look forward to working with you!

Note: After discussion with the client (and parent) it has been determined that a Crisis Plan _____ (is needed) _____ (is not needed due to low risk).