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):

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

_____

_____

_____

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

_____

_____

_____

Is There Anything Else You Want to Report?

_____

_____

_____