Initial Therapy Intake Form

Name ____ Age ________ Birthdate ______________

Address ____ Email __________________________

City _________________________________ State _____________ Zip ____________________________

Home phone ____________________ Work Phone ___________________ Cell ________________
Can a message be left on: home phone yes/no work phone yes/no cell yes/no

Occupation ________________________________ Employer _________________________________

Marital Status _____________________________ Name of spouse/partner ________________

How long have you been married/together? _______________ Children (ages) __________

If client is a minor, name of responsible adult ____

In case of emergency contact __________________________________ Phone: ________________

Address ________________________________ City ________________ State ________ Zip ______

There are times when prior medical and/or psychological records or contacts will be requested. Please make sure all information below is correct.

Do you smoke? __________ How much? _____________Drink? __________How much? _____

Have you taken illicit drugs? __________ If yes, what kind? ______________ When/how often? _____________________________________

Last medical examination ______________________ Reason ______________________________

Are you now under a doctor's care? __________ If yes, doctor's name __________________

Doctor's phone number ________________ Clinic name _________________________________

Reason for doctor's care ____

Please list any medication kind/doses ____

Reason for medication: ____

Have you ever been hospitalized for a physical illness? Describe ____________________

Have you ever been diagnosed OR hospitalized for mental health issues, personality disorder, anxiety disorder, depression, etc. Please describe: ____________________________

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Any previous therapy or counseling ____

If yes, when and number of sessions/type of counseling ______________________________

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How did you learn about my practice? ____

What do you wish to achieve with therapy? _______________________________________

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Check any of the following that may apply to you:

_____ Headaches	_____ Inferiority Feelings	_____ Shy with people
_____ Dizziness	_____ Feel tense	_____ Can't make friends
_____ Fainting spells	_____ Feel panicky	_____ Afraid of people
_____ No Appetite	_____ Fears/phobias	_____ Home conditions bad
_____ Over-eating	_____ Obsessions	_____ Unable to have fun
_____ Stomach trouble	_____ Depressed	_____ Always worried
_____ Bowel disturbances	_____ Suicidal ideas	_____ Don't like vacations
_____ Always tired	_____ Stealing	_____ Can't make decisions
_____ Always sleepy	_____ Alcoholism	_____ Over-ambitious
_____ Unable to relax	_____ Dangerous drugs	_____ Financial problems
_____ Insomnia	_____ Allergies/asthma	_____ Gambling
_____ Recurrent dreams	_____ Relationship issues	_____ Job problems
_____ Nightmares	_____ Sexual problems	_____ Can't keep a job
_____ Hallucinations	_____ Internet addictions	_____ Other (List below):

Describe presenting problem (with current symptoms: emotional, behavioral, thoughts):

History of presenting problem:

Life changes/stresses (job, marital, children, pregnancies/abortions, relationships, legal, financial, health, housing, losses, abuse, addictions):

Family structure (marriages current and past if applicable):

Legal issues (past and present):

Pastimes/hobbies/recreational activities:

Eating habits:

Education (list highest attained):

Work (occupation, job history, etc.):

Personality patterns/self-image (words you or others use to describe you):

List your strengths and accomplishments:

Spiritual/religious affiliation if applicable (as a child and presently):

Family history (drug/alcohol abuse, suicide attempts, accidents, mental health issues):

Description of childhood:

Description of parent's relationship:

Other important information about family of origin and/or issues not addressed on intake form: