Initial Therapy Intake Form

Name _____ Age_____ Birthdate _____

Address _____ Email _____

City _____ State_____ Zip _____

Home Phone _____Work Phone _____Cell Phone:_____

Can a message be left on: home phone yes/no work phone yes/no cell phone yes/no

Occupation _____ Employer _____

Marital Status _____ Name of Spouse/Partner _____

How Long Have You Been Married/Together? _____ Ages of Children _____

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 psychological records will be requested.
Please make sure that all information given below is correct.

Do You Smoke?_____How Much?_____Do You 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: _____

Reason for doctor's care: _____

Are you taking any medication?_____If yes, what kind/dosage? _____

_____

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, etc? Describe: _____

_____

_____

Any previous therapy or counseling? _____

When and number of sessions/type of counseling: _____

_____

How did you learn about my practice? _____

What do you wish to achieve with therapy? _____

_____

_____

_____

_____

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 and Phobias	☐ Home Conditions Bad
☐ Over-Eating	☐ Obsessions	☐ Unable To Have A Good Time
☐ Stomach Trouble	☐ Depressed	☐ Always Worried About Something
☐ Bowel Disturbances	☐ Suicidal Ideas	☐ Don't Like Weekends/Vacations
☐ Always Tired	☐ Take Tranquilizers	☐ Can't Make Decisions
☐ Always Sleepy	☐ Alcoholism	☐ Over-Ambitious
☐ Unable To Relax	☐ Dangerous Drugs	☐ Financial Problems
☐ Insomnia	☐ Allergy	☐ Gambling
☐ Recurrent Dreams	☐ Asthma	☐ Job Problems
☐ Nightmares	☐ Homosexuality	☐ Can't Keep A Job
☐ Hallucinations	☐ Sexual Problems	☐ 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):

Leisure activities:

Eating habits:

Education (list highest attained):

Work (occupation, job history, etc.):

Spiritual/Religious affiliation (as a child and presently):

Military history (family members in military, spouse, self):

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

List your strengths and accomplishments:

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

Description of childhood:

Description of parents' relationship:

Other important information about family of origin: