CLIENT INTAKE FORM

Please provide the following information for our records. Leave blank any question you would rather not answer, or would prefer to discuss with your therapist. Information you provide here is held to the same standards of confidentiality as our therapy.

TREATMENT HISTORY

Are you currently receiving psychiatric services, professional counseling or psychotherapy elsewhere? ( ) yes ( ) no

Have you had previous psychotherapy?
( ) no
( ) yes, with (previous therapist's name)____________________________________

Are you currently taking prescribed psychiatric medication (antidepressants, anti-anxiety or others)? ( ) yes ( ) no

If yes, please list: ____

Prescribed by: ____

Side Effects: ____

HEALTH AND SOCIAL INFORMATION

Do you currently have a primary physician? ( ) yes ( ) no

If yes, who is it? ____

Are you currently seeing more than one medical health specialist? ( ) yes ( ) no

If yes, please list: ____

When was your last doctor appointment? ___________________________________

Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.: _______________________________________

____

Are you currently on medication to manage a physical health concern? If yes, please list:

____

To the best of your knowledge, were there any complications with you during pregnancy or birth?

( ) Yes ( ) No. ____

Are you having any problems with your sleep habits? ( ) yes ( ) No

If yes, check where applicable:
( ) Sleeping too little ( ) Sleeping too much ( ) Poor quality sleep
( ) Disturbing dreams ( ) other ______________________________

How many times per week do you exercise? ______________

Approximately how long each time? _____________________

Are you having any difficulty with appetite or eating habits? ( ) no ( ) yes

If yes, check where applicable: ( ) Eating less ( ) Eating more ( ) Bingeing
( ) Restricting

Have you experienced significant weight change in the last 2 months? ( ) no ( ) yes

Do you regularly use alcohol? ( ) no ( ) yes

How many days per week do you drink any alcohol? ____________

In the past three months, what is the largest amount of alcoholic drinks you have consumed in one day?
____

Have you ever felt bad or guilty about your drinking or drug use? ( ) Yes ( ) No

Do you think you may have a problem with alcohol or drug use? ( ) Yes ( ) No

How often do you engage recreational drug use? ( ) daily ( ) weekly ( ) monthly
( ) rarely ( ) never

Have you used any street drugs in the past 3 months? ( ) Yes ( ) No

If yes, which ones? ____

Have you ever abused prescription medication? ( ) Yes ( ) No

If yes, which ones and for how long____

Do you smoke cigarettes or use other tobacco products? ( ) yes ( ) no

Suicide Risk

Have you ever had feelings or thoughts that you didn't want to live? ( ) Yes ( ) No.

If YES, please answer the following. If NO, please skip to the next section.

Do you **<u>currently</u>** feel that you don't want to live? ( ) Yes ( ) No

How often do you have these thoughts? ____

When was the last time you had thoughts of dying? ________________________________

Has anything happened recently to make you feel this way? ___________________________

____

On a scale of 1 to 10, (ten being strongest) how strong is your desire to kill yourself currently? _____

What would make it better? ____

Have you ever thought about how you would kill yourself? ( ) Yes ( ) No Explain: ___________

____

Is the method you would use readily available? _______________________________________

Have you planned a time for this? ( ) Yes ( ) No Explain: _____________________________

What would stop you from killing yourself? ____

Do you feel hopeless and/or worthless? ( ) Yes ( ) No ______________________

Have you ever tried to kill or harm yourself before? ( ) Yes ( ) No. If yes, please provide further details.

____

____

Do you have access to guns? If yes, please explain. ____

What/Who are your resources when you are having emotional difficulties? ___________________________

____

____

Have you ever experienced any of the following?

Extreme depressed mood	Yes / No
Dramatic mood swings	Yes / No
Rapid speech	Yes / No
Extreme anxiety	Yes / No
Panic attacks	Yes / No
Phobias	Yes / No
Sleep disturbances	Yes / No
Hallucinations	Yes / No
Unexplained losses of time	Yes / No
Unexplained memory lapses	Yes / No
Alcohol/substance abuse	Yes / No
Frequent body complaints	Yes / No
Eating disorder	Yes / No
Body image problems	Yes / No
Repetitive thoughts (e.g. obsessions)	Yes / No
Repetitive behaviors (e.g. frequent checking, hand washing	Yes / No
Homicidal thoughts	Yes / No
Urges to Harm Self	Yes / No
Urges to harm Others	Yes / No
Feelings of Failure	Yes / No

Extreme Disorganization or feeling Scattered	Yes / No

If yes to any of the Above, Please provide more detail below.

FAMILY BACKGROUND AND MENTAL HEALTH HISTORY

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (circle any that apply and list family member, e.g. sibling parent, uncle, grandparent, etc.)

Difficulty	**Yes / No**	**Family member**	**Pertinent Details**
Depression	Yes / No		
Bipolar disorder	Yes / No		
Anxiety disorder	Yes / No		
Panic attacks	Yes / No		
Schizophrenia	Yes / No		
Alcohol/substance abuse	Yes / No		
Eating disorders	Yes / No		
Learning disabilities	Yes / No		
Trauma history	Yes / No		

Suicide attempts	Yes / No		
Chronic illness	Yes / No		
Obsessive Compulsive	Yes / No		
ADHD	Yes / No		
Experience Trauma	Yes / No		

Were you adopted? ( ) Yes ( ) No
Where did you grow up? ____

List your siblings and their ages: ____

____

What was your father's occupation? ____

What was your mother's occupation? ____

Did your parents' divorce? ( ) Yes ( ) No If so, how old were you when they divorced? _______________

If your parents divorced, who did you live with?____

Describe your father and your relationship with him: ____

____

Describe your mother and your relationship with her: ____

____

How old were you when you left home? ____

Has anyone in your immediate family died? ( ) Yes ( ) No

Who and when? ____

Trauma History:
Do you have a history of being abused emotionally, sexually, physically or by neglect? ( ) Yes ( ) No.

Please describe when, where and by whom: ____

____

Have you experienced any other significant Trauma? ( ) Yes ( ) No If yes, provide more details __________

____

____

Educational History:

Did you Complete High School? ________ Where? __________________________

Did you attend college? ________ Where? ________________________Major? ________________________

What is your highest educational level or degree attained? ____

Occupational History:

Are you currently: ( ) Working ( ) Student ( ) Unemployed ( ) Disabled ( ) Retired

How long in present position? ____

What is/was your occupation? ____

Where do you work? ____

Are you happy with your current position? ( ) Yes ( ) No

Please list any work-related stressors, if any __________________________________

____

Have you ever served in the military? _______ If so, what branch and when? ___________________________

Honorable discharge ( ) Yes ( ) No Other type discharge ____

RELATIONSHIP HISTORY AND CURRENT FAMILY:

Are you currently: ( ) Married ( ) Partnered ( ) Divorced ( ) Single ( ) Widowed

How long in current situation? __________________

What is your spouse or significant other's occupation? ____

Are you sexually active? ( ) Yes ( ) No

How would you identify your sexual orientation? ( ) straight/heterosexual ( ) lesbian/gay/homosexual

( ) bisexual ( ) transsexual ( ) unsure/questioning ( ) asexual ( ) other ( ) prefer not to answer

On a scale of 1-10 (10 being the highest quality), how would you rate your current relationship? ________

Have you had any prior marriages? ( ) Yes ( ) No. If so, how many? ________________

How long? ____

Do you have children? ( ) Yes ( ) No If yes, list ages and gender: ___________________________________

____

Describe your relationship with your children:

____

____

List everyone who currently lives with you:

____

____

Are you currently having any conflicts in any relationships? ( ) Yes ( ) No

If Yes, With Whom? ____

Provide further details pertaining to conflicts.

____

____

In the last year, have you experienced any significant life changes or stressors? If yes, please explain:

____

____

RELIGIOUS/SPIRITUAL INFORMATION

Do you consider yourself to be religious? ( ) Yes ( ) No

If yes, what is your faith? ___________________ Do you regular attend a Church ( ) Yes ( ) No

If no, do you consider yourself to be spiritual? ( ) Yes ( ) No

Provide any information that may be helpful regarding your beliefs during Counseling: _____________

____

OTHER INFORMATION

What do you consider to be your strengths? ____

____

____

What do you like most about yourself? ____

____

What are effective coping strategies that you have learned? ______________________________________

____

____

What are your goals for therapy?

____

____

____

____

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions Code, Civil Code and HIPPA Privacy Standards. Duplication of this information for further disclosure is prohibited without prior written authorization of the client/ authorized representative to who it pertains unless other permitted by law.