CLIENT INTAKE FORM

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Your name: ____ Today's Date: ______________

Address: ____

Email address: _____________________________________ Age _____ Sex _____

Is it OK to leave non-descript messages by email (such as appointment times, cancellations, etc.) ____ yes ____ no?

Cell Phone: _______________________ Home Phone: __________________________

Is it OK to leave non-descript messages on your phone message system (such as appointment times, cancellations, etc.) _____ yes ____ no?

Emergency Contact (Name, best contact phone number, relationship) _________________________________

____

Please take your time in providing the following information. The questions are designed to help me begin to understand you so that our time together can be as productive as possible. All information provided is confidential. EMAIL YOUR RESPONSE TO ME AT LEAST 48 HOURS BEFORE OUR FIRST SESSION. PLEASE TYPE ANSWERS ON THIS DOCUMENT OR MARK YOUR RESPONSE WITH AN "X". Feel free to elaborate by using a blank piece of paper.

What is your primary reason for seeking my services?

____

____

What areas of your life have been affected by this problem? Describe why you are looking for healing.

____

____

How would you like to feel right now?

____

____

Have you experienced any significant life changes or stressful events recently?

____

____

Health

Have you ever, or are you currently experiencing, any of the following health conditions:

- Migraine headaches ___
- Chronic pain ___
- Chronic fatigue ___
- Fibromyalgia ___
- Premenstrual pain/cramps that are debilitating ___
- Irritable bowel syndrome ___ Crohn's ___
- Other forms of persistent gastrointestinal distress ___
- Severe allergies ___
- Autoimmune illness (MS, ALS, other?) ___
- Thyroid issues ___
- Rheumatoid arthritis ___
- Chronic skin conditions (eczema, psoriasis, dermatitis etc.) ___
- Depression ___
- Anxiety ___
- Panic attacks (whether explained,or for no apparent reason.) ___
- Phobias ___
- Other diagnosed mental illness from a medical doctor/specialist ___
- Other specific health problems ____

Is there anything else you'd like me to know about your health?

____

____

How would you rate your current sleeping habits?

__ Poor
__ Unsatisfactory
__ Satisfactory
__ Good
__ Very Good

If you are having problems, in which phase of sleep are you experiencing issues?

__ Falling asleep
__ Staying asleep
__ Awakening too early
__ Sleep apnea
__ Please list any other specific sleep problems you are currently experiencing:

____

How many times per week, if any, do you generally exercise? ___
What types of exercise? ____

Please describe current and previous use of alcohol and recreational drugs:

____

Do you currently smoke cigarettes? ___ Yes ___ No

Have you experienced any accidents, surgeries, or major traumatic events, either physical or emotional, within the past 2 years? Please specify.

____

Are you aware of any surgeries or accidents that are not recent, including things like a tonsillectomy, broken bone, car accident? Please specify. If you don't remember an event but you know it occurred, it's still relevant.

____

____

Are you aware of any troubling experiences from your infancy, childhood or teenager years? Include major and relatively minor events. (i.e. physical, emotional or sexual abuse, keeping a significant secret, not being heard or not being able to speak up, being bullied, losing a best friend, a close family member, a close pet, suicide of a family member or of a friend, alcoholism in the family, birth trauma such as being premature, spending time in an incubator, the use of forceps or a vacuum to aid your birth, having a high fever, infection as a baby and/or infant etc.) Please be specific to the best of your ability.

____

____

____

What childhood events (physical, emotional, cognitive, spiritual) may have contributed to who you are now?

____

____

Please list any current medications.

Medication	**Dosage**	**Condition**

Rate your general energy level on a scale of 1–10, with 1 being very low and 10 being extremely high.) _____

How would you rate your current physical health?

- ___ Poor
- ___ Unsatisfactory
- ___ Satisfactory
- ___ Good
- ___ Very Good

Are you currently receiving any type of mental health services?

___ Yes ___ No

If yes, then:

- which of the following (Please mark "X")
  - ___ Psychotherapy
  - ___ Medication
- please provide:
  - Name of provider or facility: ________________________
  - Location: ____
  - Beginning date of treatment: _________________________
  - Reason for treatment: ________________________________

Provide a brief summary of previous mental health services, including psychotherapy, inpatient or outpatient hospitalizations and approximate months/years of treatment.

____

____

Do you believe any services helpful? Were any services not helpful?

____

Family History

Please list any parents and siblings. Please use additional space on the back if needed.

Name	Age	Relationship	Whether they are living or deceased, how would you describe your relationship?

In the section below identify if there is a **family history** of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.)

Condition	Please enter "Y" or "N"	List Family Member
Alcohol/Substance Abuse		
Anxiety		
Depression		
Domestic Violence		
Sexual Abuse		
Eating Disorders		
Obesity		
Obsessive Compulsive Disorder		
Schizophrenia		
Suicide Attempts		
Other diagnosed mental health condition?		

With whom did you live while growing up? ____

What did it feel like to grow up in this family? ____

Your Marital Status: (Please Mark "X")

___ Never Married
___ Domestic Partner
___ Married
___ Separated
___ Divorced -- For how long? ________
___ Widowed: Please provide your partner's name and year deceased: ________________________

If married, how long have you been married? ________ Partner's name: ______________________________

On a scale of 1-10 (best), how would you rate your relationship? ______

Please list any **children**:

Name	Age	Comments

Additional Information

Are you employed? __ Yes __ No
If yes, what is your occupation? ___________________________________

What do you enjoy about your work? If retired, are you enjoying your life?

Do you have any wish to change your job or profession?

What do you enjoy doing in your free time? What do you do to relax?

What aspects of your life are going well, are sources of joy?

Do you consider yourself to be spiritual or religious? If so, briefly describe:

Do you have a social and/or familial support network (friends, family, spouse, church group, etc.)?

How satisfied are you with your home life? (On a scale of 1–10, 1 being very low and 10 being extremely high.) ___
Comments:

What do you consider to be some of your strengths?

What do you consider your areas that need growth?

Do you hold any identities that seem relevant to our work together? (race, gender, sexual orientation, class, ability, profession, etc.)

Is there anything else you'd like me to know about the reason you are seeking my services?