CLIENT INFORMATION INTAKE

NAME:_____DATE:_____

ADDRESS:_____CITY:_____STATE/ZIP_____

HOME:_____ CELL:_____

EMAIL:_____DOB:_____

EMERGENCY CONTACT:_____PHONE#_____

PHYSICIAN:_____PHONE#_____

EMPLOYER:_____ POSITION: _____

CURRENT PROFESSION:_____ DEGREE:_____

INSURANCE CO:_____ID#_____

GROUP #:_____OTHER INS:_____

INSURED'S NAME:_____DOB:_____

RELATIONSHIP: SINGLE:_____ MARRIED:_____DIVORCED:_____

PARTNERED:_____DATE OF MARRIAGE:_____RELIGION:_____

FAMILY INFORMATION: SPOUSE/CHILDREN/OR ELDERS LIVING WITH YOU:

NAME:_____AGE:_____ RELATIONSHIP:_____

NAME:_____AGE:_____ RELATIONSHIP:_____

NAME:_____AGE:_____ RELATIONSHIP:_____

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FAMILY OF ORIGIN INFO: YOUR PARENTS / SIBLINGS/ ELDERS YOU GREW UP WITH:

NAME: _____RELATIONSHIP_____

NAME: _____RELATIONSHIP_____

NAME: _____RELATIONSHIP_____

NAME: _____RELATIONSHIP_____

MEDICAL INFORMATION AND MENTAL HEALTH HISTORY:

MEDICATIONS CURRENT USING: _____: _____

DATE OF LAST MEDICAL APT: _____ WITH: _____ALLERGIES_____

ANY HISTORY OF HEAD INJURY: _____DATE: _____SIGNIFICANT TRAUMA: Y _____N_____

TREATMENT FOR MENTAL HEALTH PREVIOUSLY: _____Inpatient? _____
Outpatient:_____
_____

CURRENTLY IN THERAPY:_____FOR WHAT ISSUES/CONCERNS:_____

COMMENTS YOU'D LIKE TO ADD: _____

HISTORY OF MENTAL HEALTH ISSUES IN FAMILY: _____

DISORDER: _____RELATIONSHIP TO YOU:_____

DISORDER:_____RELATIONSHIP TO YOU:_____

CONCERNS THAT BRING YOU IN TODAY: _____

_____

WHAT ARE YOUR STRENGTHS AND DEPENDABLE RESOURCES:_____

_____

_____

Name_____ Date _____

Below are a list of concerns people might experience. For each item, circle in the **Current** column the number that best describes how much that problem has distressed you in the past month. Then, check the **Past** column if you have previously experienced that problem.

0 - NOT AT ALL 1- A LITTLE BIT 2 - MODERATELY 3 - QUITE A BIT 4 – EXTREMELY

PAST	CURRENT	
____	0 1 2 3 4	Depression
____	0 1 2 3 4	Feeling empty frequently
____	0 1 2 3 4	Feeling hopeless
____	0 1 2 3 4	Feeling isolated
____	0 1 2 3 4	Uncontrolled crying
____	0 1 2 3 4	Distressing mood changes
____	0 1 2 3 4	Suicidal thoughts
____	0 1 2 3 4	Feeling guilty
____	0 1 2 3 4	Feeling abandoned
____	0 1 2 3 4	Self-injury
____	0 1 2 3 4	Feeling overwhelmed
____	0 1 2 3 4	Difficulty concentrating
____	0 1 2 3 4	Sleep problems
____	0 1 2 3 4	Change in appetite
____	0 1 2 3 4	Nightmares
____	0 1 2 3 4	Racing heart
____	0 1 2 3 4	Excessive worrying
____	0 1 2 3 4	Anxiety
____	0 1 2 3 4	Panic attacks
____	0 1 2 3 4	Feeling tense
____	0 1 2 3 4	Shaking and/or sweating
____	0 1 2 3 4	Nausea
____	0 1 2 3 4	Gastro-intestinal distress
____	0 1 2 3 4	Compulsions and/or obsessions
____	0 1 2 3 4	Headaches
____	0 1 2 3 4	Specific fears or phobias
____	0 1 2 3 4	Hyperactivity
____	0 1 2 3 4	Excessive energy, spending sprees, or hypersexuality
____	0 1 2 3 4	Decreased need for sleep
____	0 1 2 3 4	Strange or bizarre thoughts
____	0 1 2 3 4	Drug or alcohol problems
____	0 1 2 3 4	Arrest or probation

PAST	CURRENT	
____	0 1 2 3 4	Bingeing and/or overeating
____	0 1 2 3 4	Feeling fat
____	0 1 2 3 4	Induced vomiting
____	0 1 2 3 4	Self-starvation
____	0 1 2 3 4	Excessive exercise
____	0 1 2 3 4	Laxative abuse
____	0 1 2 3 4	Difficulty being assertive
____	0 1 2 3 4	Shyness
____	0 1 2 3 4	Peer relationship problem
____	0 1 2 3 4	Jealousy
____	0 1 2 3 4	Overcontrolled by loved one
____	0 1 2 3 4	Difficulty with authority figures
____	0 1 2 3 4	Family relationship problems
____	0 1 2 3 4	Feeling persecuted
____	0 1 2 3 4	Romantic relationship problems
____	0 1 2 3 4	Losing temper easily
____	0 1 2 3 4	Unprovoked anger
____	0 1 2 3 4	Verbal/physical abuse to others
____	0 1 2 3 4	Work/academic difficulty
____	0 1 2 3 4	Concerns about changing career
____	0 1 2 3 4	Difficulty making career/academic decisions
____	0 1 2 3 4	Financial problems
____	0 1 2 3 4	Coming out issues
____	0 1 2 3 4	Sexual orientation concerns
____	0 1 2 3 4	Sexual problems or concerns
____	0 1 2 3 4	Physical or sexual assault
____	0 1 2 3 4	Major traumatic event
____	0 1 2 3 4	Racial or sexual harassment
____	0 1 2 3 4	Death of close friend or relative
____	0 1 2 3 4	Unwanted pregnancy
____	0 1 2 3 4	Incest or childhood molestation