Initial Therapy Intake Form

Client Name: _____ Today's Date:_____

Address:_____

City, State, Zip:_____

Gender:_____ DOB:_____ Age:_____

Relationship Status: single married domestic partner separated divorced widowed

Occupation/Work Emphasis:_____

Are you currently involved in Legal proceedings?
_____

Home Phone:_____ Okay to contact you there? Yes/No
Okay to leave a message? Yes/No

Work Phone:_____ Okay to contact you there? Yes/No
Okay to leave a message? Yes/No

Cell Phone:_____ Okay to contact you there? Yes/No
Okay to leave a message? Yes/No

Emergency Contact Name:_____ Phone:_____

Relationship to you: _____Okay to contact in the event of an emergency?___

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?_____

Do You Take Drugs? _____If yes, what kind? _____How often?_____

Last Medical Examination_____Reason _____

Are You Now Under a Doctor's Care?_____If yes, Doctor's name/number: _____

Reason for Doctor's Care: _____

Are You Taking Any Medication?_____If yes, what kind? _____

Reason for Medication: _____

Have You Ever Been Hospitalized overnight for a Physical Illness?

Describe:_____

Have you ever been hospitalized for a Mental Illness, Personality Disorder, Anxiety Disorder, etc?

Describe:_____

Previous/current Therapy/Counseling? _____If Yes, Name and Phone Numbers of Therapists:

_____

When and Number of Sessions: _____

What did you like/dislike about your previous Therapist_____

_____

Please describe your reason(s) for seeking treatment at this time. If there is a particular event that triggered your decision to seek treatment now, please explain

_____

_____

_____

_____

How have you tried to solve this incident?

_____

_____

What do you wish to Achieve with Therapy? _____

_____

_____

On a scale of 1 to 10 (with 10 as the maximum), how motivated are you to resolve this problem or difficulty?_____

Check Any of the Following That May Apply to You:

☐	Headache	☐	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	☐	Explosiveness	☐	Can't Keep A Job
☐	Hallucinations	☐	Sexual Problems	☐	Other _____

Please indicate how the issue(s) for which you are seeking treatment are affecting the following areas of your life:

	No Effect	**Little Effect**	**Some Effect**	**Much Effect**	**Significant Effect**	**Not Applicable**
Relationship						
Family						
Job/School						
Friendships						
Finances						
Physical Health						
Anxiety Level						
Mood						
Eating Habits						
Sleeping Habits						
Alcohol/Drug Use						
Sexual Functioning						
Ability to Control Anger						