



CLIENT INTAKE AND INFORMATION FORM

FOR OFFICE USE ONLY:

Date of Intake:

Record Number:

PERSONAL INFORMATION

Full Legal Name: _____

Maiden Name: _____

Any Nicknames: _____

Date of Birth: ____/____/____ (m/d/y) Age: _____

Current Mailing Address: _____

City: _____ State: _____ ZIP: _____

May we use this address to send you mail? Yes No

Please Circle Type

Primary Phone: _____ H W C May Use? Yes No

Primary Phone: _____ H W C May Use? Yes No

Primary Phone: _____ H W C May Use? Yes No

Email Address: _____ May Use? Yes No

How did you hear about us: _____

DEMOGRAPHIC INFORMATION

Height ____' ____" Weight ____lbs Gender _____ Hair Color _____ Eye Color _____
(feet" inches")

ETHNIC BACKGROUND (Please check the category or categories that best describes you)

- Asian or Pacific Islander Latino/Latina Chicano/Chicana
- Black/African American White/Caucasian Native American
- Mixed Heritage (Please Describe: _____)
- Other Ethnic Background (Please Describe: _____)

RELIGION/SPIRITUALITY

Religious/Spiritual Affiliation (Current): _____

Religious/Spiritual Heritage (Past): _____

How is religion or spirituality a resource in your life? _____



RELATIONSHIP AND/OR MARITAL STATUS (Check all that apply to you now)

Opposite-Gender Relationship:

- Single
- Primary Relationship
- Committed Relationship
- Married
- Separated
- Divorced/Dissolved Relationship
- Widowed/Partner Deceased (When: _____)

Same-Gender Relationship:

- Single
- Primary Relationship
- Committed Relationship
- Dissolved Relationship
- Partner Deceased (When: _____)

SPOUSE/PARTNER INFORMATION

How many times have you been married or been in a committed relationship? _____

What was the length of time for each of these? _____

If you are currently married or in a committed relationship: Yes No

What is your Spouse's/Partner's Name? _____

How long have you been together? _____

How long have you known one another? _____

Do you live together? Yes No

Does your Spouse/Partner (Check all that apply to you now):

Support your desire to participate in Psychotherapy? Yes No

Earn an Income? Yes No How? _____

Abuse alcohol or drugs or have any Chemical Addictions? Yes No

Describe: _____

Have a History of Psychiatric Treatment? Yes No

Describe: _____

If you are no longer married or in a committed relationship, when did you break up and why?

CHILDHOOD AND FAMILY INFORMATION (PAST)

How would you describe your family during the time you were growing up?

Distant Argumentative Not Close Close

Other (Describe: _____)

Were your parents separated or divorced? Yes No



If yes, what age were you when this happened? _____

Were you an only child? Yes No

If not, please list all siblings in birth order (including yourself), parents' names (if different), and approximate birth year (use reserve if necessary):

Sibling First Name	Gender	Mother	Father	Birth Year
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As far as you know, were you a "planned" child? Yes No

How many times did your family move before you reached the age of 18? _____

How did this affect you? _____

To whom in your family did you feel closest while growing up? _____

Explain: _____

In your opinion, did any of your family or immediate relatives have an alcohol or drug problem while you were growing up? Yes No

If yes, explain and describe how this affected you: _____

In your opinion, did any of your family or immediate relatives have a problem with controlling anger or with violence and/or abusive behavior? Yes No

If yes, explain and describe how this affected you: _____

In your opinion, did any of your family or immediate relatives have other significant problems, including, but not limited to, any of the following (if yes, please explain):

Chronic Medical Illness: Yes No (Explain: _____)

Disability: Yes No (Explain: _____)

Severe Mental Illness: Yes No (Explain: _____)

Suicide or Suicide Attempt(s): Yes No (Explain: _____)

Criminal History: Yes No (Explain: _____)

Severe Trauma: Yes No (Explain: _____)

Other: _____



Describe any major losses and/or deaths you experienced before age 18: _____

Describe your feelings and impressions about your childhood: _____

FAMILY INFORMATION (PRESENT)

Who are the people you think of when you think of "Family"? _____

Who else do you live with (Family, Friends, Roommates, Lovers, Etc)? _____

Do you have any children? Yes No

If yes, please provide their Names, Ages, Location, and Custody Status (use reverse if necessary)

	Name	Age	Location	Custody Status
Child #1:	_____	_____	_____	_____
Child #2:	_____	_____	_____	_____
Child #3:	_____	_____	_____	_____

Describe your relationship with your child(ren): _____

Describe your feelings, impressions, hopes, and disappointments about your family now: _____

EDUCATIONAL/TRAINING HISTORY

Highest year/degree of education completed: _____

(if applicable) Major Course of Study: _____

Are you currently enrolled in any educational or training program? Yes No

Where? _____

Have you ever withdrew from or dropped a course of study? Yes No

If yes, explain: _____

What are your Educational or Training Goals? _____

EMPLOYMENT HISTORY

Are you Employed? Yes No



(Check all that apply: Full Time Part Time Temporary Self-Employed)

Present or Most Recent Employer: _____

Employer's Current Mailing Address: _____

City: _____ State: _____ ZIP: _____

Work Phone: _____

What is your position or the kind of work you do? _____

Do you enjoy what you do most of the time? _____

How long have you worked in this position? _____

What are your Vocational Goals? _____

Please list Previous Jobs: _____

PERSONAL BACKGROUND AND HISTORY

Current Health Care/Medical Provider (MD, NP, etc.): _____

What is his or her phone number: _____

May we contact him or her for continuity of care? Yes No

Any history of Previous Psychotherapy? Yes No

If yes, who was your past therapist: _____

What was his or her phone number: _____

May we contact him or her for continuity of care? Yes No

Describe your reasons for terminating therapy and/or changing therapists: _____

Any history of Psychiatric Treatment? Yes No

Please Explain: _____

Any history of Medical Problems or Medical Illness? Yes No

Please Explain: _____

Any history of Substance Use or Substance Abuse? Yes No

Please Explain: _____

Any history of Physical Abuse? Yes No

Please Explain: _____

Any history of Incest or Sexual Abuse as a Child or Adolescent? Yes No

Please Explain: _____

Any history of Sexual Assault or Rape as an Adult? Yes No

Please Explain: _____

Any history of Spouse/Partner Abuse? Yes No

Please Explain: _____



Any history of Criminal Activity? Yes No

Please Explain: _____

Any history of major loss and/or death after the age of 18? Yes No

Please Explain: _____

Do you take any prescription or over the counter medications? Yes No

Name

Dose

Frequency

To Treat What?

Do you currently use alcohol or drugs? Yes No

Which Ones?

How Often?

Are any of these a problem for you?

How do you describe your sexual/affectional orientation? _____

(Select a number ranging from 0 = Totally heterosexual/affectional → 10 Totally Homosexual/affectional; 5 = Equally Bisexual/Affectional)

How do you describe your libido or sexual responsiveness? _____

How do you describe your sleeping patterns? _____

How do you describe your eating patterns? _____

THERAPEUTIC GOALS

In general, what are your reasons for seeking Counseling or Psychotherapy? _____

Why now? _____

In general, what are the goals or outcomes you would like to reach while you are participating in Counseling or Psychotherapy? _____

What are you already doing to reach these goals or outcomes? _____

How will you know when you have reached these goals or outcomes? In other words, what will be happening or your life to tell you this? _____



GENERAL QUESTIONS

What are some qualities about yourself you like? _____

What are some qualities about yourself you dislike? _____

How do you spend most of your time? _____

What do you like to do (Interests and Hobbies)? _____

How do you want to make your current life more satisfying? _____

What childhood events do you feel contributed to who you are now? _____

What events in your adult life do you feel contributed to who you are now? _____

Please state everything that you know about the circumstances surrounding your conception, intrauterine life, and birth. _____

Do you have any physiological considerations (High Blood Pressure, Seizures, Lower Back Pain, Chronic Headaches, etc)? _____

Is there anything else you would like to tell (Major Life Events)? _____

EMERGENCY CONTACT INFORMATION:

Emergency Contact Person: _____ Relationship: _____

Current Mailing Address: _____

City: _____ State: _____ ZIP: _____

Phone #1: _____ Type: H W C Phone #2: _____ Type: H W C