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Confidential Client Intake Form

Name: _____ Date: _____

Date of Birth: _____ Age: _____ Gender: _____

Address: _____ City _____ Zip _____

Home phone: _____ Okay to leave messages? Y or N

Cell phone: _____ Okay to leave messages? Y or N Okay to text? Y or N

Emergency Contact Person: _____ Relationship: _____

Contact Person Phone Number: _____

Occupation & Employer: _____

If student, school & area of study: _____

Marital/Relational Status: _____ Partner/Spouse Name: _____

Children (Names and ages):

_____

_____

Others living in your home:

_____

FAMILY HISTORY (Please circle Yes or No) If yes, please indicate who.

Depression	Y or N	Anxiety	Y or N	Bipolar	Y or N
Alcohol abuse	Y or N	Drug Abuse	Y or N	Suicide	Y or N
Psychosis	Y or N	Adoption	Y or N	Eating Disorder	Y or N
Domestic Violence	Y or N	Frequent Moves	Y or N	Homelessness	Y or N

Other illnesses, diseases, or mental disorders in family history: _____

_____

MEDICAL INFORMATION

Name, phone number, & address of physician or treating psychiatrist: _____

_____

Current or chronic health problems (specify): _____

_____

Additional Health Information: _____

_____

Current or Recent Medications (Medication, Dosage, Frequency, Prescriber): _____

_____

Have you ever given serious consideration to, or attempted to end your own life? _____

If yes, please describe:

_____

_____

_____

Do you engage in any self-harm behaviors (eg., cutting, burning, scratching, punching, hair pulling)?

_____

_____

SUBSTANCE USE

Do you currently use any mind-altering substances including, but not limited to, alcohol, marijuana, tobacco, psilocybin, LSD, DMT?

_____	_____
Substance	How much and how often?
_____	_____
Substance	How much and how often?
_____	_____
Substance	How much and how often?
_____	_____
Past Use	How much and how often?

Past substance abuse treatment? _____

TRAUMA HISTORY

Please list any past traumatic experiences you have had (including but not limited to childhood abuse, military combat, assault, natural disasters, life threatening illness).

_____

_____

_____

_____

_____

EXPECTATIONS FOR THERAPY

What do you hope to accomplish through counseling?

_____
_____
_____

What would you like to be different in your life or within yourself when you are finished with therapy?

_____
_____
_____

What are your concerns about therapy?

_____
_____

Past experiences in counseling? Positive or Negative experience?

_____
_____
_____

STRENGTHS AND RESOURCES

What helps you to make it through difficult times?

_____
_____

Who can you count on for support in times of need?

_____
_____

What gives you personal enjoyment?

_____
_____

Tell me about special skills or abilities that you have.

_____
_____

What communities are you a part of?

_____
_____

Do you have religious practices or spiritual beliefs that are important to you?

_____
_____

Please describe your cultural identity and how it is important to you.

_____
_____