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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 specify which family member.

Depression	Y or N	Anxiety	Y or N	Bipolar	Y or N
Alcoholism	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:

____

____

____

SUBSTANCE USE

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

____ ____

Substance(s) How much and how often?

____ ____

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____ ____

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____ ____

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 have you already done to deal with the difficulties?

___

___

___

What are your biggest strengths as a couple?

___

___

Past experiences in either individual or couples 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?

___

___

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

___

___

Is there anything I have not asked that is important for me to know?

___

___

Rank order the top three concerns that you have in your relationship with your partner (1 being most problematic):

1. ____
____

2. ____
____

3. ____
____

Lastly, please draw a graph indicating your level of relationship satisfaction beginning with when you met your partner. Note *pivotal/significant events* in your relationship (e.g., one of you moved out, one of you cheated).