

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:

<input type="checkbox"/>	Headache	<input type="checkbox"/>	Inferiority Feelings	<input type="checkbox"/>	Shy With People
<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	Feel Tense	<input type="checkbox"/>	Can't Make Friends
<input type="checkbox"/>	Fainting Spells	<input type="checkbox"/>	Feel Panicky	<input type="checkbox"/>	Afraid Of People
<input type="checkbox"/>	No Appetite	<input type="checkbox"/>	Fears and Phobias	<input type="checkbox"/>	Home Conditions Bad
<input type="checkbox"/>	Over-Eating	<input type="checkbox"/>	Obsessions	<input type="checkbox"/>	Unable To Have A Good Time
<input type="checkbox"/>	Stomach Trouble	<input type="checkbox"/>	Depressed	<input type="checkbox"/>	Always Worried About Something
<input type="checkbox"/>	Bowel Disturbances	<input type="checkbox"/>	Suicidal Ideas	<input type="checkbox"/>	Don't Like Weekends/Vacations
<input type="checkbox"/>	Always Tired	<input type="checkbox"/>	Take Tranquilizers	<input type="checkbox"/>	Can't Make Decisions
<input type="checkbox"/>	Always Sleepy	<input type="checkbox"/>	Alcoholism	<input type="checkbox"/>	Over-Ambitious
<input type="checkbox"/>	Unable To Relax	<input type="checkbox"/>	Dangerous Drugs	<input type="checkbox"/>	Financial Problems
<input type="checkbox"/>	Insomnia	<input type="checkbox"/>	Allergy	<input type="checkbox"/>	Gambling
<input type="checkbox"/>	Recurrent Dreams	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Job Problems
<input type="checkbox"/>	Nightmares	<input type="checkbox"/>	Explosiveness	<input type="checkbox"/>	Can't Keep A Job
<input type="checkbox"/>	Hallucinations	<input type="checkbox"/>	Sexual Problems	<input type="checkbox"/>	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						