



Adult Client Intake Form

Date of first appointment: _____

Please take your time in providing the following information. The questions are designed to help me begin to understand you so that our time together can be as productive as possible. All information provided is confidential.

Who were you referred by:

Insurance Provider: _____

Medical Provider: _____

Psychology Today

Friend/Family: _____

Other: _____

Prior Mental Health/Hospitalizations:

Have you previously received any type of mental health services?

Yes

No

If yes, which of the following:

Outpatient Psychotherapy

Medication

Outpatient Hospitalizations

Inpatient Hospitalization

If yes, please provide:

Name of provider or facility: _____

Location: _____

Dates of treatment: _____

Reason for treatment: _____

Briefly, what brings you in today

When did your problem first start? Within the last:

30 days

6--12 months

2 years

In Adolescence

In Childhood

What areas of your life have been affected because of this problem?

Are you currently experiencing overwhelming sadness, grief or depression?

Yes

No

If yes, for approximately how long? _____



Are you currently experiencing anxiety, panic attacks or have any phobias?

Yes

No

If yes, when did you begin experiencing this? _____

Please describe any major losses or traumas you have experienced:

What significant life changes or stressful events have you experienced recently?

What would you like to accomplish out of your time in therapy

Family History

Where were you born? _____

Where did you grow up? _____

City

Suburbs

Country

Please list your parents and siblings. *Please use additional space on the back if needed.* (i.e. name, age, relationship, and where they live now. If deceased, age and cause of death)

Who did you live with while growing up? _____

Mother's occupation: _____

Father's occupation? _____

Family Mental Health History:

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

Please circle yes or no and list the family member(s)

Condition	YES/NO	Name of Family Members
Alcohol/Substance Abuse	yes/no	
Anxiety	yes/no	
Depression	yes/no	
Domestic Violence	yes/no	
Sexual Abuse	yes/no	
Eating Disorders	yes/no	
Obesity	yes/no	



Obsessive Compulsive Disorder	yes/no	
Schizophrenia	yes/no	
Suicide Attempts	yes/no	
Other diagnosed mental health condition—which was:	yes/no	

Marital Status: Please circle

- Never Married
- Domestic Partner
- Married Separated
- Divorced -- For how long?
- Widowed: Please provide your partners name and year deceased:

If married, how long have you been married for and what is your partner's name:

On a scale of 1-10 (best), how would you rate your relationship? _____

Are you currently in a romantic relationship?

Yes -- How long? _____

No

On a scale of 1-10 (best), how would you rate your relationship? _____

Please list any children, (i.e. their names, and ages, relationship, and name of other parent. If deceased, age and cause of death Physical Health)

Medications:

Please list any medications, herbs, or supplements. Be sure to include the condition, as some medications are prescribed for off-label use. Continue on the back if needed, or provide a separate list. If you have a complicated medical profile, please supply supporting documentation to be able to facilitate a comprehensive understanding of your health.

Medication/Supplement	Dosage	Condition	Date Began	Date Stopped



Prescribing provider and contact information:

Name: _____
 Specialty: _____
 Facility: _____
 Phone, email, or Fax: _____

Medical History:

How would you rate your current physical health?

- Poor
- Unsatisfactory
- Satisfactory
- Good
- Very Good

Please list any specific health problems you are currently experiencing:

How would you rate your current sleeping habits?

- Poor
- Unsatisfactory
- Satisfactory
- Good
- Very Good

If you are having problems, in which phase of sleep are you experiencing issues?

- Falling asleep
- Staying asleep
- Awakening early
- Sleep apnea

Please list any other specific sleep problems you are currently experiencing:

How many times per week do you generally exercise? _____ What types of exercise do you participate in:

Are you currently experiencing any chronic pain?
 No
 Yes

If yes, please describe:

Please describe current use of alcohol, cigarettes, and/or recreational drugs:
 Please describe previous use of alcohol, cigarettes, and/or recreational drugs:



Additional Information

What do you enjoy about your work (full-time homemaker included)? If retired, what did you enjoy about your work?

What do you find particularly stressful about your current or previous work?

What do you enjoy doing in your free time? What do you do to relax?

Do you consider yourself to be spiritual or religious?

No

Yes

If yes, please describe your faith or belief: What do you consider to be some of your strengths and weakness?