

CLIENT INTAKE FORM

Client information

Today's Date _____ Name _____

Birth date _____ Age _____ Sex _____

Religion _____ Marital Status _____ Race _____

Children, name and age _____

Address _____

City _____ State _____ Zip _____

Home phone _____ Can I leave a Voicemail? _____

Cell phone _____ Can I leave a Voicemail? _____

Work phone _____ Can I leave a Voicemail? _____

E-mail _____ Can I email you? _____

Who currently resides in your household and what is their relationship to you?

What is bringing you into therapy? _____

What are your goals for therapy? _____

MEDICAL HISTORY

Medical History Current Medical Issues: _____

Current Medications: _____

Previous Medical Issues: _____

Have you sought prior counseling? _____

Are you currently taking or previously taken psychiatric medication? _____

Do you have a history of substance use or abuse? Please list substances and history _____

Have you experienced legal issues? Please list prior or current issues _____

Have you served in the military? If so, which branch and discharge status. _____

Is there a history of mental health issues, suicide or domestic violence for yourself or family members? Please list.

Are you have trouble sleeping? _____

Have you had or are experiencing sexual issues? _____

What are your strengths? _____

What are your weaknesses? _____

Are you currently employed? _____

What other information may be important for your therapist to know? _____
