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Client Intake Assessment Form

Full name:

_____
Last First Middle Initial

Name of legal parent/guardian if under 18 years:

_____
Last First Middle Initial

Birth Date ___/___/____ Age: _____ **Gender & Pronouns _____**

Relationship Status

- ❑ Single
- ❑ Domestic Partnership
- ❑ Married
- ❑ Separated/Divorced
- ❑ Widowed

Please list any children and their ages:

_____

If in a romantic relationship, how long has it been? _____

How would you rate its quality (scale 1-10): _____

***

Have you previously received any type of mental health services (psychotherapy, psychiatry, etc)?

- ❑ No
- ❑ Yes, most recent therapist/provider: _____
  - ❑ **When and why did you discontinue services with them?**

    _____

Are you currently taking any prescription medication?

- ❑ No
- ❑ Yes - Please list, name and dosage:

  _____

General and Mental Health Information

How would you rate your current physical health? *Please circle*

Poor Unsatisfactory Good Very good Excellent

Please list any specific health problems you are currently experiencing:

_____

How would you rate your sleeping habits? *Please circle*

Poor Unsatisfactory Good Very good Excellent

Please list any specific sleep problems you are currently experiencing:

_____

Do you participate in any exercise during the week?

- ❑ No
- ❑ Yes - what & how often _____

Please list any difficulties you experience with your appetite or eating patterns

_____

Are you currently experiencing overwhelming sadness or depression?

- ❑ No
- ❑ Yes - since: _____

Are you currently experiencing grief from a loss?

- ❑ No
- ❑ Yes - describe loss and length of time since loss

_____

Have you ever experienced a trauma or stressor so severe it overwhelmed your coping abilities?

- ❑ No
- ❑ Yes

Are you currently experiencing anxiety, panic attacks or specific fears?

- ❑ No
- ❑ Yes - specify what and duration

_____

Are you currently experiencing chronic pain?

- ❑ No
- ❑ Yes - please describe _____

Do you drink alcohol?

- ❑ No
- ❑ Yes - frequency and amount: _____

Do you engage in recreational drug use?

- ❑ No
- ❑ Yes - What, and frequency: _____

Family Mental Health History

Please identify if there is a family history of any of the following, and indicate their relationship to you (e.g. sibling, grandparent, uncle, etc)

Issue:	**List Family Member(s)**

- ❑ Alcohol/Substance Abuse
- ❑ Anxiety
- ❑ Depression
- ❑ Post-traumatic Stress Disorder
- ❑ Domestic Violence
- ❑ Eating disorders
- ❑ Obsessive Compulsive Behavior
- ❑ Schizophrenia
- ❑ Suicide Attempts

Additional Information

What is your employment status?

- ❑ Employed Full Time - Where: _____
- ❑ Employed Part-Time - Where:_____
- ❑ Student - Where: _____
- ❑ Unemployed but looking for work
- ❑ Unemployed and not looking
- ❑ Retired

Do you enjoy your work? Is work a particular stressor for you?

_____

Do you have any open Custody, Protective Services or other legal cases?

If yes, please describe:

_____

_____

_____

Do you consider yourself to be spiritual or religious?

- ❑ No
- ❑ Yes - describe your faith or belief: _____

What do you (or did you) enjoy doing during free time?

_____
_____
_____

What do you consider to be some of your strengths?

_____
_____
_____

What do you consider to be some of your weaknesses?

_____
_____
_____

What would you like to accomplish during our time together in therapy?

_____
_____
_____

What is something you wish people understood about you?

_____
_____
_____

Anything else you feel I should know before we meet?

_____
_____
_____