Client name _____

CLIENT INTAKE FORM

Please rate any of the following symptoms you may be experiencing:

Mild = Impacts quality of life, but no significant impairment of day-to-day functioning
Moderate = Significant impact on quality of life and/or day-to-day functioning
Severe = Profound impact on quality of life and/or day-to-day functioning

Symptom	**Impact**			
	None	Mild	Moderate	Severe
Addiction	☐	☐	☐	☐
Aggressive Behaviors	☐	☐	☐	☐
Agitation	☐	☐	☐	☐
Appetite Disturbance	☐	☐	☐	☐
Delusions	☐	☐	☐	☐
Depressed Mood	☐	☐	☐	☐
Dissociative States	☐	☐	☐	☐
Elevated Mood	☐	☐	☐	☐
Fatigue/Low Energy	☐	☐	☐	☐
Generalized Anxiety	☐	☐	☐	☐
Grief	☐	☐	☐	☐
Guilt	☐	☐	☐	☐
Hallucinations	☐	☐	☐	☐
Hopelessness	☐	☐	☐	☐
Hyperactivity	☐	☐	☐	☐
Irritability	☐	☐	☐	☐
Mood Swings	☐	☐	☐	☐
Obsessions/Compulsions	☐	☐	☐	☐
Panic Attacks	☐	☐	☐	☐
Paranoid Ideation	☐	☐	☐	☐
Phobias	☐	☐	☐	☐
Poor Concentration	☐	☐	☐	☐
Sexual Dysfunction	☐	☐	☐	☐
Significant Weight Gain/Loss	☐	☐	☐	☐
Sleep Disturbance	☐	☐	☐	☐
Social Isolation	☐	☐	☐	☐
Somatic Complaints	☐	☐	☐	☐
Substance Abuse	☐	☐	☐	☐
Worthlessness	☐	☐	☐	☐

Client name _____

IN THE CONTEXT OF THE PAST 18 MONTHS RATE THE FOLLOWING IN THE BOX BESIDE THE DESCRIPTION
USING A SCALE OF 1-3. 1= *NEVER* 2 = *OCCASIONALLY* 3 = *OFTEN*

M1

	chronic sadness		low frustration tolerance
	crying episodes		irritability
	hopelessness		sleep problems
	difficulty concentrating		memory problems
	weight loss		thoughts of suicide
	weight gain		withdrawing from others
	loss of appetite		difficulty functioning at work
	overeating		difficulty functioning socially
	nausea/vomiting		low energy/fatigue
	difficulty making decisions		reduced interest/pleasure
	recurring thoughts of death or dying		feelings of worthlessness/guilt
	mood swings		staying up for days without sleep

A1

	agitation		panic attacks
	restlessness		fear of leaving home
	excessive worry		avoidance of public places
	fearfulness		avoidance of social situations
	trembling/shaking		pounding heart/palpitations/ shortness of breath
	fear of loss of control		chest pain
	fear of dying		flashbacks/re-living bad experiences
	feeling detached from others/life		easily startled/upset
	intrusive thoughts of bad memories		difficulty waiting your turn
	nightmares		obsessive or compulsive

ED1

	excessive eating		obesity
	underweight		self-induced vomiting
	use of laxatives		obsessing about food, diet, exercise
	eating problems interfering with health		

ATTFOC1

	difficulty completing tasks/distractible		taking on more tasks than can be completed
	difficulty focusing		frequent forgetfulness
	racing thoughts		Inability to organize one's self and environment

Client name _____

BEH1

	tendency to be impulsive		difficulty at work/do not stay on the same job
	excessive gambling		difficulty adjusting to new situations
	excessive spending		problems in school growing up
	aggressive/abusive toward others		aggressive/abusive toward others
	high risk sexual behavior		relationship conflicts

BEHII

	inability to trust others		grandiose sense of self, with little empathy for others
	lack of desire for intimacy, difficulty expressing emotions		fear of rejection from others resulting in avoiding people, events
	problems with legal authorities		difficulty in making decisions for self without the advice of others
	volatile, unstable relationships, personal and/or professional		preoccupation with orderliness, perfectionism, and control

What prompted you to seek therapy at this time?

_____

_____

_____

_____

Who is impacted by the issue?

_____

_____

What have you already done to try to solve the issue? What has helped (even if only a little) and what has failed to help?

_____

_____

_____

What are your goals for therapy at this time?

_____

_____

_____

Client name _____

Family of Origin

Present during childhood

	Present entire childhood	Present part of childhood	Not Present at all
mother	☐	☐	☐
father	☐	☐	☐
stepmother	☐	☐	☐
stepfather	☐	☐	☐
brother(s)	☐	☐	☐
sister(s)	☐	☐	☐
other	☐	☐	☐

Parents' current marital status

☐ married to each other
☐ separated for ____ years
☐ divorced for ____ years
☐ mother remarried ____ times
☐ father remarried ____ times
☐ mother involved with someone
☐ father involved with someone
☐ mother deceased for____ years
age at mother's death ____
☐ father deceased for ____ years
age at father's death ____

Describe childhood family experience

☐ outstanding home environment
☐ normal home environment
☐ chaotic home environment
☐ witnessed physical/verbal/sexual abuse
☐ experienced physical/verbal/sexual abuse

Immediate Family

Marital status

☐ single, never married
☐ engaged ___ months
☐ married for _ years
☐ divorced for _ years
☐ separated for _____ years
☐ divorce in process _ months
☐ live-in for ___ years
☐ _____ prior marriages (self)

Intimate relationship

☐ never been in a serious relationship
☐ not currently in relationship
☐ currently in a serious relationship

Relationship satisfaction

☐ very satisfied with relationship
☐ satisfied with relationship
☐ somewhat satisfied with relationship
☐ dissatisfied with relationship
☐ very dissatisfied with relationship

Client name _____

Substance Use History (check all that apply)

Family alcohol/drug abuse history

☐ father
☐ mother
☐ grandparent(s)
☐ sibling(s)
☐ other
☐ stepparent/live-in
☐ uncle(s)/aunt(s)
☐ spouse/significant other
☐ children

_____

Substance use status

☐ no history of abuse
☐ active abuse
☐ early full remission
☐ early partial remission
☐ sustained full remission
☐ sustained partial remission

Patient Treatment history

☐ outpatient (age[s]) _____
☐ Inpatient (age[s]) _____
☐ 12-step program (age[s]) _____
☐ stopped on own (age[s]) _____
☐ other (age[s]) _____

Substances used	First use age	Last use age	Current Use	Frequency
☐ alcohol	_____	_____	☐	_____
☐ amphetamines/speed	_____	_____	☐	_____
☐ barbiturates	_____	_____	☐	_____
☐ cocaine	_____	_____	☐	_____
☐ crack cocaine	_____	_____	☐	_____
☐ hallucinogens (e.g., LSD)	_____	_____	☐	_____
☐ caffeine	_____	_____	☐	_____
☐ marijuana or hashish	_____	_____	☐	_____
☐ opioids	_____	_____	☐	_____
☐ prescription	_____	_____	☐	_____
☐ other	_____	_____	☐	_____

Psychiatric medications

List all psychiatric medications taken over past five years and currently

Medication Reason Dosage and frequency Prescribing doctor name

_____

_____

_____

_____

_____

Client Signature _____ Date _____