**Adult Client Intake Form**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_ 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**.

**Referred by:**

\_\_Medical Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_Insurance Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_My Website: https://empowerment-therapy-center.com/ PsychologyToday

\_\_Friend/Family: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you previously received any type of mental health services?** \_\_Yes \_\_No

If yes, which of the following?:

\_\_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 the problem first start?** Within the last: \_\_30 days \_\_6--12 months \_\_2 years \_\_During adolescence \_\_During 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? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*Any Suicidal Thoughts?**\_\_ Current? \_\_Past? - How long ago?\_\_\_\_\_\_\_\_ Notes:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are you currently experiencing anxiety, panic attacks or have any phobias?** \_\_Yes \_\_No

If yes, when did you begin experiencing this? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*Any history of self-harm?** \_\_Current? \_\_Past? – How long ago?\_\_\_\_\_\_\_ Notes:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*Any thoughts about harming others?** \_\_Current? \_\_Past? – How long ago? \_\_\_\_\_\_\_ Notes:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**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.

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| --- | --- | --- | --- | --- |
| **Name** | **Age** | **Relationship** | **Where do they live now?** | **If deceased, age and cause of death** |
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Who did you live with while growing up? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mother's occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Father's occupation? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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.).

|  |  |  |
| --- | --- | --- |
| **Condition** | **Please Circle** | **List Family Member** |
| 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? | Yes / No: Which was?: |  |

**Marital Status:**

\_\_Never Married \_\_Domestic Partner \_\_Married \*\*If married, how long have you been married for and

 what is your partners name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

\_\_Separated \_\_Divorced -- For how long? \_\_\_\_\_\_\_\_\_

\_\_Widowed: Please provide your partners name and year deceased: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are you currently in a romantic relationship?**

\_\_Yes -- How long? \_\_\_\_\_\_\_ On a scale of 1-10 (best), how would you rate your relationship? \_\_\_\_\_

\_\_No

What is your Gender?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Preferred pronoun(s)?\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your Sexual Orientation?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any issues related to gender or sexual orientation that might be relevant to treatment?

**Please list any children, their names, and ages:**

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| --- | --- | --- | --- | --- |
| **Name** | **Age** | **Relationship** | **Name of other parent** | **If deceased, age and cause of death** |
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**Physical Health**

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.

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| **Medication/Supplement** | **Dosage** | **Condition** | **Date Began/Stopped** |
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**Prescribing provider(s) and contact information:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Specialty: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Facility: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone, email, or Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

\_\_Poor \_\_Unsatisfactory \_\_Satisfactory \_\_Good \_\_Very Good

**Please list any specific and significant 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:

**Substance Use**

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

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

**Additional Information**

**Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**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? If yes, please describe your faith or belief:**

**What do you consider to be some of your weaknesses?**

**What do you consider to be some of your strengths?**

**Reviewed by (Therapist/Supervisor):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_

 Print Signed Date

\*See biopsychosocial assessment for additional notes\*