

Initial Therapy Intake Form

Name _____ Age _____ Birthdate _____

Address _____ Email _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone: _____

Occupation _____ Employer _____

Marital Status _____ Name of Spouse/Partner _____

How Long Have Both of You Been Together? _____ Ages of Children _____

If Client is a Minor, Name of Responsible Adult _____

Name of Closest Friend/Relative _____ Phone _____

Address _____ City _____ State _____ Zip _____

*There are times when prior medical and psychological records will be requested.
Please make sure that all information given below is correct.*

Do You Smoke? _____ How Much? _____ Do You Drink? _____ How Much? _____

Have you taken illicit drugs? _____ If yes, what kind? _____ When/How often? _____

Last Medical Examination _____ Reason _____

Are You Now Under a Doctor's Care? _____ If yes, Doctor's name: _____

Reason for doctor's care: _____

Are you taking any medication? _____ If yes, what kind? _____

Reason for medication: _____

Have you ever been hospitalized for a physical illness? Describe: _____

Have you ever been diagnosed or hospitalized for a mental illness, personality disorder, anxiety disorder, etc? Describe: _____

Any previous therapy or counseling? _____

When and number of sessions/type of counseling: _____

How did you learn about us? _____

What do you wish to achieve with therapy? _____

Check Any of the Following That May Apply to You:

- | | | |
|---|---|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Inferiority Feelings | <input type="checkbox"/> Shy With People |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Feel Tense | <input type="checkbox"/> Can't Make Friends |
| <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Feel Panicky | <input type="checkbox"/> Afraid Of People |
| <input type="checkbox"/> No Appetite | <input type="checkbox"/> Fears and Phobias | <input type="checkbox"/> Home Conditions Bad |
| <input type="checkbox"/> Over-Eating | <input type="checkbox"/> Obsessions | <input type="checkbox"/> Unable To Have A Good Time |
| <input type="checkbox"/> Stomach Trouble | <input type="checkbox"/> Depressed | <input type="checkbox"/> Always Worried About Something |
| <input type="checkbox"/> Bowel Disturbances | <input type="checkbox"/> Suicidal Ideas | <input type="checkbox"/> Don't Like Weekends/Vacations |
| <input type="checkbox"/> Always Tired | <input type="checkbox"/> Take Tranquilizers | <input type="checkbox"/> Can't Make Decisions |
| <input type="checkbox"/> Always Sleepy | <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Over-Ambitious |
| <input type="checkbox"/> Unable To Relax | <input type="checkbox"/> Dangerous Drugs | <input type="checkbox"/> Financial Problems |
| <input type="checkbox"/> Insomnia | <input type="checkbox"/> Allergy | <input type="checkbox"/> Gambling |
| <input type="checkbox"/> Recurrent Dreams | <input type="checkbox"/> Asthma | <input type="checkbox"/> Job Problems |
| <input type="checkbox"/> Nightmares | <input type="checkbox"/> Homosexuality | <input type="checkbox"/> Can't Keep A Job |
| <input type="checkbox"/> Hallucinations | <input type="checkbox"/> Sexual Problems | <input type="checkbox"/> Other |