CLIENT INTAKE FORM

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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
☐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 your 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? ______________________________

Are you currently experiencing anxiety, panic attacks or have any phobias?
☐Yes ☐No

If yes, when did you begin experiencing this? ______________________________

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.

Name	Age	Relationship	Where do they live now?

If deceased, age and cause of death: ____

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? If yes, which was:	Yes / No	__________

Marital Status

☐ Never Married ☐ Domestic Partner ☐ Married ☐ Separated ☐ Divorced – For how long? _____ ☐ Widowed

If married, how long have you been married for and what is your partner's name?

____

On a scale of 1–10 (best), how would you rate your relationship? _____

Are you currently in a romantic relationship?
☐ Yes – How long? _____ ☐ No

On a scale of 1–10 (best), how would you rate your relationship? _____

Please list any children, their names, and ages:

Name	Age	Relationship	Name of other parent	If deceased, age and cause of death

Physical Health

Please list any medications, herbs, or supplements. Be sure to include the condition, as some medications are prescribed for off-label use.

Medication/Supplement	Dosage Condition	Date Began/Stopped

____
____

Prescribing provider 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 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?
☐ Yes ☐ No
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

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 strengths?

____

What do you consider to be some of your weaknesses?

____

Consent and Policies

The standard fee is $85 per 38–67 minute session. We also have a sliding fee scale for those whose income cannot support the standard fee. Annually we review fees.

Appointments and Cancellations

Appointments are 38–67 minutes and are set at a certain time on a certain day. Since we hold that time for you, there is a charge for appointments cancelled less than 48 hours before your appointment. Be sure to talk about this with your therapist.

Liability

Providence Counseling has Professional Liability Insurance for each individual counselor and Business Liability Insurance for all its locations.

Signature

I am 18 years of age or older, or, I have legal custody of this minor child(ren). I understand and accept the above information and I authorize these services.

Client's signature ___________________ Date ___________

Therapist's signature _______________ Date ___________