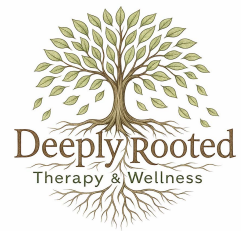


Therapy Intake Form



General Information

Name

Date of Birth

Age

Address

City

State

Zip Code

Phone #

Email

Is it ok to leave messages at this phone number? ☐ Yes ☐ No May I contact you via email? ☐ Yes ☐ No

Emergency Contact Name

Phone #

Race: ☐ White ☐ Black/African American ☐ Asian ☐ Latinx/Hispanic ☐ Native American ☐ Multi-racial

Birth sex: ☐ Female ☐ Male ☐ Intersex ☐ Prefer not to disclose

Gender: ☐ Female ☐ Male ☐ Non-binary ☐ Transgender ☐ Prefer not to disclose

Preferred pronouns

Spirituality

Community Involvement:

Family Involvement

Family Information

Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Widowed ☐ Divorced ☐ Separated ☐ _____

Spouse/Partner

Age

Lives with you? ☐ Y ☐ N

How satisfied are you with your relationship? ☐ Very Satisfied ☐ Satisfied ☐ Neutral ☐ Unsatisfied ☐ Very Unsatisfied

Do you have children? ☐ Yes ☐ No If no, please skip to the next section.

Child

Age

Lives with you? ☐ Y ☐ N

Child

Age

Lives with you? ☐ Y ☐ N

Child

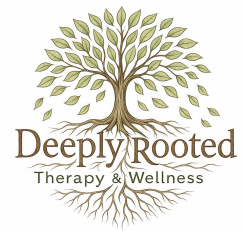
Age

Lives with you? ☐ Y ☐ N

Child

Age

Lives with you? ☐ Y ☐ N



Family History

Who were you raised by?

How many siblings do you have?

Please describe your relationship with your parents/caregivers:

Please describe names, ages, and respective relationships with your siblings:

If there are any circumstances from your childhood that you'd like to elaborate on, please do so here:

Support System

Do you have a support system? ☐ Yes ☐ No

Please explain:

What is your current living situation?

Is your home environment safe? ☐ Yes ☐ No

If no, please explain why:

Employment/Education Status

Employer/School

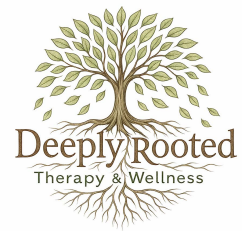
Occupation/Years in School

Please check all that apply:

- | | | |
|---|---|-------------------------------------|
| ☐ Disabled | ☐ Employed Part Time | ☐ Unemployed |
| ☐ Employed Full Time | ☐ Retired | ☐ Student |

What is your highest level of education completed?

- | | | |
|--|--|---|
| ☐ Less Than High School | ☐ Associates Degree | ☐ Bachelor's Degree |
| ☐ High School/GED | ☐ Some College | ☐ Post Graduate Degree |



Mental Health History

Have you experienced any of the following in the past 90 days? Please check all that apply:

- | | | |
|--|---|---|
| ☐ ADHD | ☐ Hospitalization | ☐ Racing Thoughts |
| ☐ Anger/Rage | ☐ Obsessive/Intrusive Thoughts | ☐ Self Injury |
| ☐ Anxiety | ☐ Mood Swings | ☐ Suicide Attempt |
| ☐ Death in Family | ☐ Panic/Phobia | ☐ Thoughts of Harming Others |
| ☐ Depression | ☐ Paranoia/Delusions | ☐ Violence |
| ☐ Hallucinations | ☐ Poor Sleep Patterns | ☐ Weight Gain/Loss |

Have you experienced abuse? ☐ Yes ☐ No

If yes, please explain:

Have you ever been admitted to the hospital for mental health reasons? ☐ Yes ☐ No

If yes, please explain:

Is there any family history of mental health problems or suicide (attempts)? ☐ Yes ☐ No

If yes, please explain:

Have you had therapy in the past? ☐ Yes ☐ No If yes, was it helpful? ☐ Yes ☐ No

Previous therapist

Dates seen

Medical History

Are you currently taking any medications? ☐ Yes ☐ No

If yes, please list:

Have you had any surgeries or operations? ☐ Yes ☐ No

If yes, please list:

Do you currently have any medical problems? ☐ Yes ☐ No

If yes, please list all symptoms and treatments you are undergoing:

Do you experience physical pain that causes mental health issues? ☐ Yes ☐ No

Physician

Phone Number

Permission to contact physician? ☐ Yes ☐ No



Stressors

What stressors are you dealing with or have you dealt with in the past? Please check all that apply:

- | | | |
|---|--|--|
| ☐ Alcohol/Drug Abuse | ☐ Divorce | ☐ Physical/Sexual Abuse |
| ☐ Attempted Suicide | ☐ Financial Crisis/Unemployment | ☐ Psychiatric Illness |
| ☐ Death | ☐ Frequent Relocations | ☐ Serious illness |
| ☐ Debilitating Injuries/Disabilities | ☐ Legal Problems | ☐ Other _____ |

Personal History

What symptoms are you dealing with? Please check all that apply:

- | | | |
|---|--|--|
| ☐ Appetite Problems | ☐ Hopelessness | ☐ OCD Symptoms |
| ☐ Concentration Problems | ☐ Low Interest/Motivation | ☐ Panic Attacks |
| ☐ Energy Levels | ☐ Mood Swings | ☐ Thoughts of Self-harm/Suicide |
| ☐ Flashbacks | ☐ Nightmares | ☐ Trouble Sleeping |
| | | ☐ Other _____ |

How long have you been dealing with these?

What effect do these have on your life? ☐ Minimal ☐ Mild ☐ Moderate ☐ Severe

Habits & Lifestyle

Do you regularly drink alcohol? ☐ Yes ☐ No

If yes, how often: Are you dealing with any addictions? ☐ Yes ☐ No

If yes, please explain:

How often do you engage in recreational drug use? ☐ Never ☐ Rarely ☐ Monthly ☐ Weekly ☐ Daily

Do you consider your alcohol/drug use a problem? ☐ Yes ☐ No. ☐ Unsure

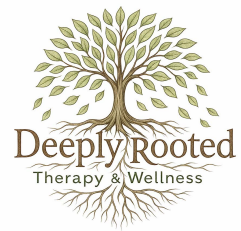
Do you exercise regularly? ☐ Yes ☐ No

If yes, please describe what you do and how often:

Do you have hobbies? ☐ Yes ☐ No

If yes, what are they and how often do you do them?

What do you do for fun?



Legal Summary

Have you or are you dealing with any of the following legal issues? Please check all that apply:

- | | | |
|---|--------------------------------------|--|
| ☐ Custody/Divorce | ☐ Fraud | ☐ Substance Abuse |
| ☐ Driving Offenses | ☐ Immigration | ☐ Violence |

Have you ever been imprisoned? ☐ Yes ☐ No

If yes, please explain:

Are you court ordered for services? ☐ Yes ☐ No If no, please skip to the next section.

Are you assigned to a probation officer or case worker? ☐ Yes ☐ No

If yes, please list them here: Name:

Phone Number:

Will you require progress reports for legal authorities? ☐ Yes ☐ No

Goal Information

Please answer the following questions to the best of your ability:

Why are you seeking treatment at this time?

What would you like to change about yourself or your circumstances?

What gives you hope, purpose, and meaning?

What do you hope to get from treatment?