Confidential Client Intake

This form helps me understand you before we begin. Answer what feels right to share; we can talk through anything you leave blank. You may type in the fields or print and write by hand.

> In a crisis right now, call or text **988**, call **911**, or go to your nearest emergency room. Please do not send this form by regular email. Return it through the secure upload in Doxy.me when I request it, or bring it to your first session.

Contact information

FULL NAME

DATE OF BIRTH

PRONOUNS (OPTIONAL)

PREFERRED NAME (OPTIONAL)

STREET ADDRESS

CITY

STATE

ZIP

HOME PHONE

☐ You may leave a message ☐ Please do not leave a message

CELL OR WORK PHONE

☐ You may leave a message ☐ Please do not leave a message

EMAIL

☐ You may contact me by email for scheduling ☐ Please do not email me

EMPLOYER OR SCHOOL

OCCUPATION OR FIELD OF STUDY

Emergency contact

NAME

PHONE

RELATIONSHIP

Stress in the last 12 months

Please mark any that apply.

☐ Serious illness or injury ☐ Death of a close friend or family member ☐ Major illness in the family
☐ Job change or other transition ☐ New family member ☐ Relationship difficulty, separation, or divorce
☐ Pregnancy or fertility challenges

OTHER STRESSORS

Family

Relationship status

_ Single _| Partnered _| Living together _ Engaged _| Married _ Separated |_ Divorced _ Remarried
Widowed

NAMES AND AGES OF CHILDREN

ARE YOUR PARENTS LIVING?

NAMES AND AGES OF SIBLINGS

Do any of your relatives have a history of mental illness? | Yes | No

WHEN YES, PLEASE EXPLAIN

Counseling goals

WHAT BRINGS YOU TO COUNSELING AT THIS TIME?

HOW HAVE THESE CONCERNS CHANGED OVER TIME?

WHAT ARE YOUR GOALS FOR OUR WORK TOGETHER?

Counseling history

Have you received counseling or psychiatric care before? | Yes | No

WHEN

WITH WHOM

PURPOSE AND RESULTS

Medications and treatment

Have you ever been prescribed medication, herbs, or supplements for depression or another mental health condition? | Yes | No

WHEN

PRESCRIBING CLINICIAN

MEDICATION

FOR WHAT

RESULTS

Are you currently taking any medications? | Yes | No

PLEASE LIST THEM

Are you currently taking any vitamins or supplements? | Yes | No

WHICH ONES

Have you ever been hospitalized for a psychiatric or emotional health reason? | Yes | No

WHEN

WHERE

REASON AND OUTCOME

Have you ever been in a drug, alcohol, or other treatment program? | Yes | No

WHEN

WHERE

REASON AND OUTCOME

Alcohol and substances

Do you currently drink alcohol? | Yes | No

HOW MUCH AND HOW OFTEN

Do you currently use recreational drugs, including cannabis? | Yes | No

WHICH, HOW MUCH, AND HOW OFTEN

Do you feel you have a problem with alcohol or drugs? | Yes | No

Physical health

Overall physical health (choose one)

Very good Good Average | Poor

ANY RECENT WEIGHT GAIN OR LOSS

Do you drink caffeine? | Yes | No

WHAT AND HOW MUCH

PHYSICIAN OR PRIMARY CARE PROVIDER: NAME, ADDRESS, AND PHONE

What do you typically eat in a day?

BREAKFAST

LUNCH

DINNER

GLASSES OF WATER PER DAY

SURGERIES, ACCIDENTS, OR SERIOUS ILLNESSES, WITH DATES

Have you been hospitalized in the last year for any reason? | Yes | No

WHEN

WHERE

REASON AND OUTCOME

Safety

These questions are part of every intake. Your answers help me support you well. In a crisis right now, call or text 988 or call 911.

Have you ever attempted or seriously considered suicide? ☐ Yes ☐ No

WHEN YES, PLEASE SHARE ANY DETAILS YOU ARE COMFORTABLE SHARING

Have you ever hurt yourself on purpose, such as cutting? ☐ Yes ☐ No

WHEN YES, PLEASE SHARE ANY COMMENTS OR THOUGHTS

Identity and meaning

How significant a role does spirituality play in your life? (Choose one.)

☐ None ☐ Somewhat important ☐ Significant ☐ Very significant

Does race or culture play a significant role in your life? ☐ Yes ☐ No

WHEN YES, HOW

Anything else

IS THERE ANYTHING ELSE YOU WOULD LIKE ME TO KNOW BEFORE WE BEGIN?

HOW DID YOU HEAR ABOUT MY SERVICES?

COMPLETED BY (PRINTED NAME)

DATE