CLIENT INFORMATION / INTAKE SHEET

Personal Information

Today's Date: ______________________

Print Full Name:____

DOB:__________ Age: _______ Sex:______ Gender Identity: ________

Preferred Pronouns? He / She / They

Parent/Legal Guardian (if under 18):

____

Home Address:____

____

Mailing Address, if different: __________________________________

____

Cell Phone: __________________________________
May we leave a message? □ Yes □ No

Home/Work/Other Phone: _________________________
May we leave a message? □ Yes □ No

Email: ____
May we leave a message? □ Yes □ No
*Please note: Email correspondence is not considered to be a confidential medium of communication.

Relationship Status: □ Never Married Number of marriages: ______

□ Current Marriage ______ (how long?) □ Separated _____ (how long?)

□ Divorced _____ (how long?) □ Widowed ______ (how long?)

□ Domestic Partnership _______ (how long?)

Children and Dependents

Number of births? _____ Number of Stillbirths or Miscarriages? _______

Please list any children and ages that live with you: (Please indicate relationship, i.e Bio, Step, Adopted, Foster)

Please list any children and ages not living with you: (Please indicate relationship, i.e. Bio, Step, Adopted, or Foster)

Please list any adults and ages currently living with you: (Please indicate relationship)

Emergency Contact # 1

Name: ____

Relationship to Client: ____

Phone Number: ____

Emergency Contact #2

Name: ____

Relationship to Client: ____

Phone Number: ____

Preferred Hospitial
In case of medical emergency while engaged in a therapy session, preferred hospital to be transported to?

____

Mental Health Treatment History

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)? ◻ No ◻ Yes, previous therapist/practitioner: ____

Have you ever been prescribed psychiatric medication? ◻ Yes ◻ No
Please list and provide dates:
____

Psychiatric Care Provider: _______________________________________

Current Psych Medication List:____________________________________

Primary Care Physician: ____

Current Prescription Medication List other than Mental Health:

____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health? (please circle)
   Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:

____

2. How would you rate your current sleeping habits? (please circle)
   Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:

____

3. How many times per week do you generally exercise? ___________

What types of exercise to you participate in:

____

4. Please list any difficulties you experience with your appetite or eating patterns, if any.

____

5. Are you currently experiencing overwhelming sadness, grief or depression? ◻ No ◻ Yes
If yes, for approximately how long? __________________________

6. Have you ever experienced any suicidal thoughts or attempts? ◻ No ◻ Yes
If yes, when? ____

7. Are you currently experiencing anxiety, panic attacks or have any phobias? ◻ No ◻ Yes
If yes, when did you begin experiencing this? _________________________

8. Are you currently experiencing any chronic pain? ◻ No ◻ Yes
If yes, please describe? ____

9. Have you ever experienced or been witness to any type of trauma or traumatic event? ◻ No ◻ Yes
If yes, please describe:____

10. Do you drink alcohol? ◻ No ◻ Yes
If yes, how much and how often? _____________________________________

11. How often do you engage recreational drug use?
◻ Daily ◻ Weekly ◻ Monthly ◻ Infrequently ◻ Never

12. Are you currently in a romantic relationship? ◻ No ◻ Yes
If yes, for how long? ____________________

On a scale of 1-10, how would you rate your relationship? _______________

13. What significant life changes or stressful events have you experienced recently:

____

____

14. Have you been to therapy in the past? If so, what for? What was your experience like? _____________________ ____________________________
____
____

14. What brought you to seek therapy at this time? ____________________
____
____
____

FAMILY MENTAL HEALTH HISTORY

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.).

Please Circle		List Family Relationship
Alcohol/Substance Abuse	yes/no	
Anxiety	yes/no	
Depression	yes/no	
Domestic Violence	yes/no	
Eating Disorders	yes/no	
Obesity	yes/no	
Obsessive Compulsive Behavior	yes/no	
Schizophrenia	yes/no	
Suicide Attempts	yes/no	

Employment Status

Are you currently employed or a full-time student? □ No □ Yes
If yes, what is your current employment/educational situation:

____

What is your profession or area of interest? _________________________

Do you enjoy your work/school? □ No □ Yes

Is there anything stressful about your current work/school?

____

Highest Education Level Completed: ________________________________

Military Status

Are you or have you ever been in the US Military? □ No □ Yes
If yes, what is your current status? _________________________________
Branch of Service:____________ Current/Highest Rank Achieved: ________
How long have you served? ______________________________________
If prior service, what was your discharge status? ______________________

Have you ever been deployed to combat zones, have been witness to or experienced any type of trauma? ___No ___Yes. If Yes, when/where?____

Spirituality / Religion

Do you consider yourself to be spiritual or religious? □ No □ Yes
If yes, describe your faith or belief:

____

Strengths and Challenges

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

____

____

What do you consider to be some of your personal challenges?

____

____

Personal Goals for Therapy

What would you like to accomplish out of your time in therapy?

____

____

____

____

Please add any other additional information that you feel is important to know about you?

____

____

____

8. How did you hear about our services?

□ Psychology Today □ WeCounsel □ Internet Search □ Friend/Relative

□ Professional Referral □ Other _______________

Please note:

*Must provide a copy of insurance card.

*An official photo ID is required to validate identity of person requesting/participating in services and a copy is required to maintain on file.

*A valid credit/debit card must be kept on file under your **wecounsel** account for billing purposes. (Co-pays, counseling fees, missed appointment fees, etc.)

Client Signature: ______________________________ Date: _________
If electronic signature, please print name and check here ☐
(Parent/guardian signature if under the age of 18.)
Print Name (First, MI, Last) ______________________________________