

# Client Intake Form

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*This information is maintained in confidence in your record. Disclosure of information only occurs with express written permission via a Release of Information form.*

**Today's Date:**

**Who referred you to me:**

## A. Client Information

**Who is this form for?**

- Adult seeking therapy
- Couple or Family seeking therapy
- Parent completing form for child/teen (16 and under)
- Teen (16+) completing with parent assistance

### Primary Client (Adult or Child/Teen)

**Name & Pronouns:**

**Date of Birth: Age:**

**Address:**

**Phone: Email:**

**Phone restrictions:**

**Name & Pronouns:**

**Date of Birth: Age:**

**Address:**

**Phone: Email:**

**Phone restrictions:**

### For Youth Clients Only

**Grade Level/Year in College:**

**School:**

**Cell phone (if applicable):**

## Parent/Guardian Information (if completing for youth)

Parent 1 Name: Phone:

Parent 2 Name: Phone:

Parents' relationship:

- Married -  Divorced -  Separated -  Single parent -  Other:

## B. Relationship Status (Adult Clients)

Current Status:

- Married -  Single -  Divorced -  Widowed -  Separated -  Long-term relationship

How do you get along with your current spouse/partner/co-parent?

- Very well -  Well -  Fair -  Poorly -  Not applicable

Additional Information:

## C. Children Information (All Adult Clients)

Do you have children? -  Yes -  No

Child/Children's Name/s

Age:

Grade:

School:

Current Concerns:

## D. Developmental History (For Youth Clients)

Early Development Concerns (if yes, please explain)

Pregnancy concerns: -  None -  Yes:

**Birth complications:** -  None -  Yes:

**Feeding:** -  Breastfed \_\_\_months -  Bottle fed -  Combination

**Developmental Milestones (Check if typical timing)**

- Rolling over (4-6 months)
- Crawling (7-10 months)
- Walking (9-15 months)
- First words (10-14 months)
- Toilet training (age: )
- Concerns with any milestones:

Additional Information:

**Preschool/Daycare**

**Attended:** -  Yes -  No

**Ages:** How did it go?

**Sleep History (For Youth Clients)**

Where did your child sleep as an infant?

- Own room -  Parents' room -  Parents' bed -  Other:

Current/past sleep concerns:

- None -  Difficulty falling asleep -  Night waking -  Early waking
- Nightmares -  Night terrors -  Bedwetting -  Other:

- **What have you tried?**

## E. Current Concerns

### Primary Concern

Main difficulty bringing you/your child to therapy:

### Additional Concerns (Check all that apply)

- Depression -  Anxiety -  Relationship issues -  Work stress
- Grief/loss -  Trauma -  Substance use -  Sleep problems
- Other:

### For Youth:

- Behavioral problems -  School issues -  Peer relationships
- Family conflicts -  Sleep problems -  Emotional outbursts
- Attention/focus -  Developmental concerns
- Other:

## F. Treatment History

Previous therapy/counseling: -  Yes -  No

If yes: When? With whom?

For what?

Results:

Previous psychiatric hospitalization: -  Yes -  No

If yes, when and why:

## G. Current Medications

Taking psychiatric medications: -  Yes -  No

Medication/s and amount:

Prescribing Doctor:

For what Condition and how long have you been taking it:

Additional Information:

Please let me know if you'd like me to coordinate with any other professionals currently working with you/your child (such as therapists, doctors, school counselors, or teachers). I'm happy to provide a Release of Information form so we can communicate and work together to offer more comprehensive support.

## H. Family & Medical History

### Family Mental Health History

Family history of: (Check all that apply)

- Depression -  Anxiety -  Bipolar disorder -  Schizophrenia
- Substance abuse -  Suicide -  Other:

### Medical Information

Recent pediatrician visit date (for youth):

Medical issues ruled out: -  Yes -  No -  N/A

Extra Health or Medical Information:

Current health problems:

- None -  Sleep disorders -  Chronic pain -  Other:

## I. Abuse History

Have you/your child experienced abuse? -  No -  Yes

If yes, please indicate: (P=Physical, S=Sexual, E=Emotional, N=Neglect)

Type:

**Age(s):**

**By whom:**

**Who was told:**

**Effects:**

**Additional Information:**

## **J. Substance Use (Adults/Teens)**

**CAGE Questions:**

- Have you felt the need to **Cut down** on drinking/substance use? -  Yes -  No
- Have you felt **Annoyed** by criticism of your use? -  Yes -  No
- Have you felt **Guilty** about your use? -  Yes -  No
- Have you taken an **Eye opener** (morning drink/substance)? -  Yes -  No

**Additional Substance Information:**

**Legal issues due to substance use:** -  Yes -  No

If yes, please explain:

**Current use:**

- Alcohol: \_\_\_\_\_ drinks/week
- Tobacco: \_\_\_\_\_ amount/week
- Other substances: \_\_\_\_\_

## **K. School & Work (As Applicable)**

## **School Information (Youth)**

**Academic strengths:**

**Academic challenges:**

**Behavioral concerns at school:** -  Yes -  No

**Details:**

## **Employment (Adults)**

**Current status:**

- Employed full-time -  Employed part-time -  Student
- Unemployed -  Retired -  Other:

**Type of work:**

**Additional Information:**

## **L. Relationships & Social**

### **Parenting Style (Parents)**

**How would you describe your parenting style?**

- Authoritative (firm but warm) -  Authoritarian (strict)
- Permissive (lenient) -  Uninvolved -  Combination

**How are strong emotions handled in your family?**

**Discipline approach:**

### **Social Relationships**

**Family Relationships:**

- Very close -  Close -  Fair -  Poor -  Complicated

Peer relationships:

- Many friends -  Few close friends -  Some difficulty -  Significant problems

Support network (names and relationship):

## M. Additional Information for Youth

### Behavioral Patterns

Transitional objects: -  None -  Blanket -  Stuffed animal -  Other:

How does your child handle transitions?

- Very well -  Generally well -  Some difficulty -  Major problems

Child's greatest strengths:

Areas needing growth:

### For Youth Using Technology

Media use in household (type of tech, content and time management):

Cell phone for social purposes: -  Yes -  No

Additional Tech/Social Information or Concerns:

Topics addressed at home:

- Sex education: -  Yes -  No -  Age-appropriate
- Substance use: -  Yes -  No -  Briefly

- Bullying: -  Yes -  No -  As needed

## **N. Goals & Expectations**

What do you hope to gain from therapy for yourself, your family, and/or your child?

Any other significant information to share:

Legal matters, custody issues, or other concerns:

I/we have read, discussed if necessary, and understand this Intake Document and everything included is accurate and up to date information to the best of my/our knowledge.

Client/Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Client/Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Client/Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*Thank you for taking the time to complete this comprehensive form. This information will help provide the best possible care and is held in strict confidence.*