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?

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

Additional Information:

C. Children Information (All Adult Clients)

Do you have children? - [ ] Yes - [ ] No

Child Name	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)

For Adults/Youth:

- [ ] 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	Prescribing Doctor	For What Condition	How Long

Additional Information:

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

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

Relationship with your parents or your child's parents/caregivers:

- [ ] Very close - [ ] Close - [ ] Fair - [ ] Poor - [ ] Complicated

Peer relationships:

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

Support network:

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: _____

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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.