Client Name	

CLIENT INTAKE FORM

Please provide the following information for our records. Leave blank any question you would rather not answer. Information you provide is maintained within the strict confidentiality guidelines of this practice. Please complete the form and bring with you to your first session. Use back of form for additional information and comments.

CLIENT INFORMATION

Today's Date	DOB	Registration and Release Form Received and Signed		Yes / No
		Client Financial Agreement & Office Policies Signed		Yes / No
Name	(First)	(Middle)	(Last)	(Preferred)
Legal Guardian Name (if minor)				

THERAPY

1. What brings you to see me today?	
2. Are you presently in therapy? YES / NO	If yes with whom?
3. Previous therapy? With whom, what kind, how long?	
4. How were you referred to me?	

EMPLOYMENT

5. Employer		6. Occupation	
7. Job Status	❍Full time ❍Part time ❍Student ❍Retired ❍Unemployed ❍Unemployed (looking for work) ❍Unemployed (disability/leave)		
8. Job Satisfaction / Feelings about being unemployed?			

EDUCATION

9. Highest grade completed?	❍ High School ❍GED ❍Vocational ❍Some College ❍Bachelors ❍Graduate Degree
10. Area of studies?	
11. Learning disabilities?	
12. Future educational goals?	

Client Name	

FAMILY / RELATIONHIPS

13. Relationship status?	❍Single (not involved) ❍Single (currently involved) ❍Dating ❍Married ❍Divorced ❍Separated ❍Widowed ❍Other (please explain)
14. Living Situation?	❍Alone ❍With Spouse/Significant Other ❍Family ❍Friend / Roommate
15. Satisfaction with living situation?	

16. Briefly describe your present relationship with your spouse or partner and how long you've been in it.

17. Briefly describe relationships with any significant ex's.

18. Number of children?		19. How many living with you?	

Name	Age	Relationship status and description. (include if you are biological, adopted or step parent)	Lives with you
			Yes / No
			Yes / No
			Yes / No
			Yes / No
			Yes / No
			Yes / No
			Yes / No

20. Family History — If deceased, how old were YOU when they died? Any known psychiatric illness? Relationship description.

	Name	Age	Alive	
Mother				
Father				
Sibling				
Sibling				
Sibling				
Sibling				
Sibling				

21. Were you raised by biological parents?	Yes / No	If no by whom?	
22.Were your parents divorced?	Yes / No	If yes impact on you?	

23. Any other important/significant people in your life (past or present) eg. relatives, teachers, friends

24. Any significant deaths or losses?

25. Describe you major support system today.

PHYSICAL & MENTAL HEALTH

Client Name	

26. Current Physical Health Status	❍Good ❍Problems	If problems please explain.
If problems, has doctor completed a medical release if needed for body based work?		Yes / No
27. Date of last medical exam and outcomes.		
28. Current physician's name		Phone
29. Alternative care provider		Phone

30. Medication(s) Name	Dose	Frequency	Reason	Prescribed by

31. Trouble sleeping?	Yes / No	❍Sleep too little ❍Sleep too much ❍Poor quality ❍Disturbing dreams
32. Change in eating habits?	Yes / No	❍Eating less ❍Eating more ❍ Binging ❍Restricting
Have you experienced ❍significant weight gain ❍significant weight loss		How much
33. Do you use alcohol regularly?	Yes / No	If yes please describe?
34. How often do you engage in recreational drug use?		❍Daily ❍Weekly ❍Monthly ❍Rarely ❍Never
35. Do you, friends, or family feel you have a problem with alcohol or drugs?	Yes / No	If yes please explain.
36. Have you ever been hospitalized for drugs or alcohol?	Yes / No	If yes please explain.
37. Any other additiction issues?	Yes / No	If yes please explain.
38. Do you attend any 12 step meetings?	Yes / No	If yes please explain.
35. Any current mental health problems, for example with depression or anxiety?	Yes / No	If yes please explain.
39. Are you presently having any thoughts about wanting to harm yourself?	Yes / No	If yes please explain
40. Any history around thinking about suicide or attempting to take your life?	Yes / No	If yes please explain
Age at previous attempts	Were you hospitalized? Yes / No	Medications

41. Have you ever planned or attempted to hurt or harm another person?	Yes / No	If yes please explain

MILITARY / LEGAL

42. Have you served in the military?	Yes / No	Veteran of War?	Yes / No	Enlisted Dates	
How did this impact your life?					

43. Have you ever been arrested for a crime?	Yes / No	If yes, date of arrest
Nature of arrest		Status

LEISURE / SPIRITUALITY

44. What kinds of hobbies and interests do you have?		
45. What kind of physical activity do you do?		
46. Are you a member of any religious organization or spiritual practice?	Yes / No	If yes please explain
47. How important is spirituality in your life?		

PSYCHOSEXUAL

48. Do you have any issues around sexuality that you want to address in therapy?		
49. If you are in a relationship, is your sex life satisfactory?		
50. What is your sexual orientation?		
51. How do you feel about yourself as a man/ woman?		
52. Do you practice safe sex?		
53. Have you ever been sexually abused or raped?	Yes / No	If yes please explain

CORE ENERGETICS & GOALS

54. Core Energetics works with the mind, body and spirit. How is that important to you and why?
55. Name three characteristics of yourself that you like.
56. Name three characteristics about yourself that you want to change or transform.
57. What do you hope to get out of therapy?