



**CLIENT INTAKE AND INFORMATION FORM**

Date of Intake: \_\_\_\_\_ Record Number: \_\_\_\_\_

**PERSONAL INFORMATION**

Full Legal Name: \_\_\_\_\_  
 Any Nicknames: \_\_\_\_\_  
 Current Mailing Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ May Use? Y  N   
 Work Phone: \_\_\_\_\_ May Use? Y  N   
 Cell Phone: \_\_\_\_\_ May Use? Y  N   
 Email Address: \_\_\_\_\_ May Use? Y  N   
 How did you hear about us: \_\_\_\_\_

**DEMOGRAPHIC INFORMATION**

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_  
 Height \_\_\_\_\_ Weight \_\_\_\_\_ Hair Color \_\_\_\_\_ Eye Color \_\_\_\_\_  
 Gender \_\_\_\_\_

**ETHNIC BACKGROUND** (Please check the category that best describes you)

\_\_\_\_ Asian or Pacific Islander      \_\_\_\_ Latino/Latina      \_\_\_\_ Chicano/Chicana  
 \_\_\_\_ Black/African American      \_\_\_\_ White/Caucasian      \_\_\_\_ Native American  
 \_\_\_\_ Mixed Heritage (Please Describe) \_\_\_\_\_  
 \_\_\_\_ Other Ethnic Background (Please Describe) \_\_\_\_\_

**RELIGION/SPIRITUALITY**

Religious/Spiritual Affiliation (Current): \_\_\_\_\_  
 Religious/Spiritual Heritage (Past): \_\_\_\_\_  
 How is religion or spirituality a resource in your life? \_\_\_\_\_

**RELATIONSHIP AND/OR MARITAL STATUS** (Check all that apply to you now)

Opposite-Gender Relationship:	Same-Gender Relationship:
____ Single	____ Single
____ Primary Relationship	____ Primary Relationship
____ Committed Relationship	____ Committed Relationship
____ Married	____ Dissolved Relationship
____ Separated	____ Partner Deceased (When: _____)
____ Divorced/Dissolved Relationship	
____ Widowed/Partner Deceased (When: _____)	



**SPOUSE/PARTNER INFORMATION**

How many times have you been married or been in a committed relationship? \_\_\_\_\_

What was the length of time for each of these? \_\_\_\_\_

If you are married or in a committed relationship:

- What is your Spouse's/Partner's Name? \_\_\_\_\_
- How long have you been together? \_\_\_\_\_
- How long have you known one another? \_\_\_\_\_
- Do you live together?  Yes  No

Does your Spouse/Partner (Check all that apply to you now):

- Support your desire to participate in Psychotherapy?  Yes  No
- Earn an Income?  Yes  No
  - How? \_\_\_\_\_
- Abuse alcohol or drugs or have any Chemical Addictions?  Yes  No
  - Describe \_\_\_\_\_
- Have a History of Psychiatric Treatment?  Yes  No
  - Describe \_\_\_\_\_
- If you are no longer married or in a committed relationship, when did you break up and why? \_\_\_\_\_

**CHILDHOOD AND FAMILY INFORMATION (PAST)**

How would you describe your family during the time you were growing up?

- \_\_\_\_\_ Distant \_\_\_\_\_ Argumentative \_\_\_\_\_ Not Close \_\_\_\_\_ Close \_\_\_\_\_ Other

Were your parents separated or divorced? \_\_\_\_\_

- If yes, what age were you when this happened? \_\_\_\_\_

Were you an only child?  Yes  No

- If not, what was your birth order or sequence amongst your siblings? \_\_\_\_\_

As far as you know, were you a "planned" child?  Yes  No

How many times did your family move before you reached the age of 18? \_\_\_\_\_

- How did this affect you? \_\_\_\_\_



To whom in your family did you feel closest while growing up? \_\_\_\_\_

- Explain: \_\_\_\_\_  
 \_\_\_\_\_

In your opinion, did any of your family or immediate relatives have an alcohol or drug problem while you were growing up?  Yes  No

- If yes, explain and describe how this affected you: \_\_\_\_\_  
 \_\_\_\_\_

In your opinion, did any of your family or immediate relatives have a problem with controlling anger or with violence and/or abusive behavior?  Yes  No

- If yes, explain and describe how this affected you: \_\_\_\_\_  
 \_\_\_\_\_

In your opinion, did any of your family or immediate relatives have other significant problems, including, but not limited to, any of the following (please explain):

- Chronic Medical Illness: \_\_\_\_\_
- Disability: \_\_\_\_\_
- Severe Mental Illness: \_\_\_\_\_
- Suicide or Suicide Attempt(s): \_\_\_\_\_
- Criminal History: \_\_\_\_\_
- Severe Trauma: \_\_\_\_\_
- Other: \_\_\_\_\_

Describe any major losses and/or deaths you experienced before age 18: \_\_\_\_\_  
 \_\_\_\_\_

Describe your feelings and impressions about your childhood: \_\_\_\_\_  
 \_\_\_\_\_

**FAMILY INFORMATION (PRESENT)**

Who are the people you think of when you think of "Family"? \_\_\_\_\_  
 \_\_\_\_\_

Who else do you live with (Family, Friends, Roommates, Lovers, Etc)? \_\_\_\_\_  
 \_\_\_\_\_



Do you have any children?  Yes  No

- If yes, please provide their Names, Ages, Location, and Custody Status

	Name	Age	Location	Custody Status
<input type="radio"/> Child #1:	_____	_____	_____	_____
<input type="radio"/> Child #2:	_____	_____	_____	_____
<input type="radio"/> Child #3:	_____	_____	_____	_____
<input type="radio"/> Child #4:	_____	_____	_____	_____

- Describe your relationship: \_\_\_\_\_  
 \_\_\_\_\_

Describe your feelings, impressions, hopes, and disappointments about your family now: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**EDUCATIONAL/TRAINING HISTORY**

Highest year of education completed: \_\_\_\_\_ Major Course of Study: \_\_\_\_\_

Are you currently enrolled in any educational or training program?  Yes  No

- Where? \_\_\_\_\_

Have you ever withdrew from or dropped a course of study?  Yes  No

- If yes, explain: \_\_\_\_\_  
 \_\_\_\_\_

What are your Educational or Training Goals? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**EMPLOYMENT HISTORY**

Are you Employed?  Yes  No

Present or Most Recent Employer: \_\_\_\_\_

- Full Time  Part Time  Temporary  Self-Employed

Current Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Work Phone: \_\_\_\_\_

What is your position or the kind of work you do? \_\_\_\_\_

Do you enjoy what you do most of the time? \_\_\_\_\_

How long have you worked in this position? \_\_\_\_\_

What are your Vocational Goals? \_\_\_\_\_

Please list Previous Jobs: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_



**PERSONAL BACKGROUND AND HISTORY**

Current Health Care/Medical Provider (MD, NP, etc.) \_\_\_\_\_

- What is his or her phone number: \_\_\_\_\_
- May we contact him or her for continuity of care?  Yes  No

Any history of Previous Psychotherapy?  Yes  No

- If yes, who was your past therapist: \_\_\_\_\_
- What was his or her phone number: \_\_\_\_\_
- May we contact him or her for continuity of care?  Yes  No
- Describe your reasons for terminating therapy and/or changing therapists: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Any history of Psychiatric Treatment?  Yes  No

- Explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Any history of Medical Problems or Medical Illness?  Yes  No

- Explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Any history of Substance Use or Substance Abuse?  Yes  No

- Explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Any history of Physical Abuse?  Yes  No

- Explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Any history of Incest or Sexual Abuse as a Child or Adolescent?  Yes  No

- Explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Any history of Sexual Assault or Rape as an Adult?  Yes  No

- Explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



Any history of Spouse/Partner Abuse?  Yes  No

• Explain: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Any history of Criminal Activity?  Yes  No

• Explain: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Any history of major loss and/or death after the age of 18?  Yes  No

• Explain: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Do you take any prescription or over the counter medications?  Yes  No

Which Ones?	Name	Dose	Frequency
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do you currently use alcohol or drugs?  Yes  No

Which Ones?	How Often?	Are any of these a problem for you?
_____	_____	_____
_____	_____	_____
_____	_____	_____

How do you describe your sexual/affectional orientation? (Mark an "X" where you see yourself)

0	1	2	3	4	5	6
Totally Heterosexual/Affectional		Bisexual/Affectional		Totally Homosexual/Affectional		

How do you describe your sleeping patterns? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

How do you describe your eating patterns? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

How do you describe your libido or sexual responsiveness? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_



**THERAPEUTIC GOALS**

In general, what are your reasons for seeking Counseling or Psychotherapy? \_\_\_\_\_

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Why now? \_\_\_\_\_

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In general, what are the goals or outcomes you would like to reach while you are participating in Counseling or Psychotherapy? \_\_\_\_\_

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What are you already doing to reach these goals or outcomes? \_\_\_\_\_

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How will you know when you have reached these goals or outcomes? In other words, what will be happening or your life to tell you this? \_\_\_\_\_

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**GENERAL QUESTIONS**

What are some qualities about yourself you like? \_\_\_\_\_

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What are some qualities about yourself you dislike? \_\_\_\_\_

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and Training Institute®**  
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How do you spend most of your time? \_\_\_\_\_

\_\_\_\_\_

What do you like to do (Interests and Hobbies)? \_\_\_\_\_

\_\_\_\_\_

How do you want to make your current life more satisfying? \_\_\_\_\_

\_\_\_\_\_

What childhood events do you feel contributed to who you are now? \_\_\_\_\_

\_\_\_\_\_

What events in your adult life do you feel contributed to who you are now? \_\_\_\_\_

\_\_\_\_\_

Please state everything that you know about the circumstances surrounding your conception,  
intrauterine life, and birth. \_\_\_\_\_

\_\_\_\_\_

Do you have any physiological considerations (High Blood Pressure, Seizures, Lower Back Pain,  
Chronic Headaches, etc)? \_\_\_\_\_

\_\_\_\_\_

Is there anything else you would like to tell (Major Life Events)? \_\_\_\_\_

\_\_\_\_\_

**EMERGENCY CONTACT INFORMATION:**

Emergency Contact Person: \_\_\_\_\_

Relationship: \_\_\_\_\_

Current Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

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