



12351 W. 96TH TER. SUITE 108, LENEXA, KS 66215

CLIENT INTAKE FORM

Please answer the following questions to the best of your ability. These questions are intended to help the therapist with the therapy process. All information is completely confidential.

Personal Information

Today's date _____

Name: _____
(Last) (First) (Middle Initial)

Name of parent or guardian (if minor): _____
(Last) (First) (Middle Initial)

Birth Date: ____/____/____ Age: ____ Gender: Male Female

Marital Status: Never married Partnered Married Separated Divorced Widowed

Number of Children: ____ Ages: _____

Current Address: _____

Home Phone: _____ May we leave a message? Yes No

Cell/other: _____ May we leave a message? Yes No

Email: _____ May we email you? Yes No

**NOTE: Emails may not be confidential*

Referred by: _____

Are you currently receiving psychological services, professional counseling, psychiatric services, or any other mental health services? Yes No

Reason for change: _____

Have you had any mental health services in the past? Yes No

Reason for change: _____

Are you currently taking any psychiatric prescription medications? Yes No

If yes, please list: _____

Have you ever been prescribed a psychiatric prescription medication? Yes No

If yes, please list: _____

General Health and Mental Health Information

How is your physical health at the present time?

Poor Unsatisfactory Satisfactory Good Very good

Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, thyroid dysfunction, etc.):

Are you on any medication for physical/medical issues? Yes No

If yes, please list: _____

Are you having any problems with your sleep habits? Yes No

If yes, check which applies: Sleep too much Sleep too little Poor quality Disturbing dreams

Other: _____

How many hours sleep do you average in night? _____

How many times per week do you exercise? _____ days _____ minutes/hours

Are there any changes or difficulties with your eating habits? Yes No

If yes: Eating less Eating more Binging Restricting

Have you experienced a weight change in the last two months? Yes No

Have you been diagnosed with an Eating Disorder? Yes No If yes, what is the diagnosis? _____

Have you been treated for an Eating Disorder? Yes No

Do you consume alcohol regularly? Yes No

In one month, how many times do you have 4 or more drinks in a 24-hour period? _____

How often do you engage in recreational drug use?

Daily Weekly Monthly Rarely Never

Have you felt depressed recently? Yes No

If yes, for how long? _____

List your symptoms of depression. _____

Have you had any suicidal thoughts recently? Yes No

If yes: Frequently Sometimes Rarely

Have you had suicidal thoughts in your past? Yes No
If yes, how long ago?_____ How often? Frequently Sometimes Rarely
Do you engage in any form of self-harm? Yes No If yes, please list _____

Are you currently in a romantic relationship? Yes No
If yes, how long have you been in this relationship?_____

On a scale from 1-10, how would you rate the quality of your relationship (10 being great)? _____

In the last year, have you had any major life changes (e.g. new job, new home, illness, relationship change, etc.)?

Quick Check

Check the boxes of the symptoms you have experienced.

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Extreme depressed mood | <input type="checkbox"/> Mood swings | <input type="checkbox"/> Rapid speech | <input type="checkbox"/> Extreme anxiety |
| <input type="checkbox"/> Panic attacks | <input type="checkbox"/> Phobias | <input type="checkbox"/> Disturbed sleep | <input type="checkbox"/> Hallucinations |
| <input type="checkbox"/> Memory lapse | <input type="checkbox"/> Alcohol/substance abuse | <input type="checkbox"/> Body complaints | <input type="checkbox"/> Eating disorder |
| <input type="checkbox"/> Repetitive thoughts | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Time loss | <input type="checkbox"/> Repetitive behaviors |
| <input type="checkbox"/> Homicidal thoughts | <input type="checkbox"/> Suicide attempts | <input type="checkbox"/> Trouble planning | <input type="checkbox"/> Relationship trouble |
| <input type="checkbox"/> Aggression | <input type="checkbox"/> Angry | <input type="checkbox"/> Addictive Behavior | <input type="checkbox"/> Anhedonia |
| <input type="checkbox"/> Bereavement | <input type="checkbox"/> Dissociation | <input type="checkbox"/> ↑Hopelessness | <input type="checkbox"/> ↑ Helplessness |
| <input type="checkbox"/> PTSD | <input type="checkbox"/> Pornography Use | <input type="checkbox"/> Sexual Addiction | <input type="checkbox"/> Tearful |
| <input type="checkbox"/> Worry | <input type="checkbox"/> Sexual Concerns | <input type="checkbox"/> Bingeing | <input type="checkbox"/> Purging |
| <input type="checkbox"/> Restricting Intake | <input type="checkbox"/> Depression | <input type="checkbox"/> Impulsiveness | <input type="checkbox"/> Compulsions |

Have you been abused sexually, emotionally or physically? Please describe briefly.

Occupational Information

Are you currently employed? Yes No
If yes, who is your employer?_____What is your position?_____
Are you happy in your current position? Yes No
Are you fulfilled in your current position? Yes No
Does your work make you stressed? Yes No
If yes, what are your work-related stressors?_____

Religious/Spiritual Information

Do you practice a religion? Yes No If yes, what is your faith? _____
If no, do you consider yourself to be spiritual? Yes No

Family Mental Health History

The following is to provide information about your family history. Please, mark each as yes or no. If yes, please indicate the family member affected.

<i>Issue</i>			<i>Family Member</i>
Depression	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Anxiety Disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Bipolar Disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Panic Attacks	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Alcohol/Substance Abuse	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Eating Disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Learning Disability	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Trauma History	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Domestic Violence	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Obesity	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Obsessive Compulsive Behavior	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Schizophrenia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____

Other Information

List your strengths _____

List areas you feel you need to develop _____

What do you like most about yourself? _____

What are some ways you cope with obstacles and stress?

What are your goals for therapy? What would you like to accomplish?
