

Client Intake Form

Last Name		Current Date	
First Name/MI		Birth Date	
Street Address		Phone/Home	
City/State/Zip		Phone/Other	
Education Level		Emergency Contact Name/Number (release to be signed)	
Occupation		Employer How long there	
Email Address			

Medical Information

Primary Care Clinic		Location/Address	
Primary Care Physician		Last Medical appointment	
Other Doctors/Therapists	1.	2.	3.
Medical History & Problems	Allergies to Medications:		Health is rated as: <input type="checkbox"/> Excellent <input type="checkbox"/> Fair <input type="checkbox"/> Good <input type="checkbox"/> Poor
<input type="checkbox"/> I do not have a primary care doctor			
Hospitalizations/Dates :	Reason for hospitalization	All Medications/Dosage/ Frequency:	
Hospitalizations for Mental health: <input type="checkbox"/> yes <input type="checkbox"/> no			

Family of Origin Information

Present during childhood: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Stepmother <input type="checkbox"/> Stepfather <input type="checkbox"/> Brother(s) <input type="checkbox"/> Sister(s) <input type="checkbox"/> Other (specify)	Present part of childhood: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Stepmother <input type="checkbox"/> Stepfather <input type="checkbox"/> Brother(s) <input type="checkbox"/> Sister(s) <input type="checkbox"/> Other (specify)	Not Present at all: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Stepmother <input type="checkbox"/> Stepfather <input type="checkbox"/> Brother(s) <input type="checkbox"/> Sister(s)	Parent's marital status: <input type="checkbox"/> Married to each other <input type="checkbox"/> Separated for ___ years <input type="checkbox"/> Divorced for ___ years <input type="checkbox"/> Mother remarried ___x's <input type="checkbox"/> Father remarried ___x's <input type="checkbox"/> Mother involved w/someone <input type="checkbox"/> Father involved w/someone <input type="checkbox"/> Mother deceased ___ years <input type="checkbox"/> Father deceased ___ years
Special Circumstances in Childhood Home:		Describe Childhood Family Experience: <input type="checkbox"/> Outstanding/Supportive <input type="checkbox"/> Normal <input type="checkbox"/> Chaotic <input type="checkbox"/> Witnessed abuse _____ <input type="checkbox"/> Experienced abuse _____	
Age and circumstances in leaving childhood home:			
Please note any familial mental health history:		Note family history of medical disease:	

Please note any familial alcohol or drug problems:

Do you have any significant event or losses that have impacted your life? Please discuss...

Relationship History

Relationship Status: <input type="checkbox"/> single, never married <input type="checkbox"/> engaged _____ months <input type="checkbox"/> married for _____ years <input type="checkbox"/> partnered/coupled for _____ years <input type="checkbox"/> divorced for _____ years <input type="checkbox"/> separated for _____ years <input type="checkbox"/> divorce in process for _____ months and/or _____ years	Re: Intimate Relationship <input type="checkbox"/> never dated <input type="checkbox"/> never in relationship <input type="checkbox"/> not in relationship now <input type="checkbox"/> currently in relationship Relationship satisfaction: <input type="checkbox"/> very satisfied <input type="checkbox"/> satisfied <input type="checkbox"/> somewhat satisfied <input type="checkbox"/> dissatisfied <input type="checkbox"/> very dissatisfied	Persons currently in home: Name: _____ age/gender _____ _____ _____ _____ List those NOT in Home: _____ _____ _____ _____ Discuss frequency of contact/visits:	Relationship to client: _____ _____ _____ _____ _____ _____ _____
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Discuss any **past** or **current** significant issues in **intimate** relationships:

Discuss any **past** or **current** significant issues in other/or **immediate family** relationships:

Social History

Describe your **support network, extended family connections and friendships and their importance to you:**

Describe your **leisure activities/hobbies:**

Describe your **ethnic and cultural background:**

Describe your **spiritual or religious identity/preference:**

Briefly list **past jobs/occupations/length of employment:**

Discuss any **occupational problems** and indicate nature of the problem (performance, relational, safety):

Briefly list any **legal or court problems** and indicate whether past or present:

You may use the back side of this document if you need more space.

