CLIENT INTAKE FORM

Client Name
Address 1
Address city/state
email

Date of first appointment:

Please take your time in providing the following information. The questions are designed to help me begin to understand you so that our time together can be as productive as possible. All information provided is confidential.

Referred by:

- ☐ Medical Provider: _____
- ☐ My Website:
- ☐ PsychologyToday
- ☐ Friend/Family: _____
- ☐ Other: _____

Have you previously received any type of mental health services?

- ☐ Yes
- ☐ No

If yes, which of the following:

- ☐ Psychotherapy
- ☐ Medication
- ☐ Outpatient Hospitalizations
- ☐ Inpatient Hospitalization

Briefly, what brings you in today?

When did your problem first start? Within the last:

- ☐ 30 days
- ☐ 6--12 months
- ☐ 2 years
- ☐ During adolescence
- ☐ During childhood

Are you currently experiencing overwhelming sadness, grief or depression?

- ☐ Yes
- ☐ No

If yes, for approximately how long? _____

Physical Health

Please list any medications, herbs, or supplements. Be sure to include the condition, as some medications are prescribed for off-label use. Continue on the back if needed, or provide a separate list. If you have a complicated medical profile, please supply supporting documentation to be able to facilitate a comprehensive understanding of your health.

Medication/Supplement	Dosage	Condition	Date Began/Stopped

Prescribing provider and contact information:

Name: _____

Specialty: _____

Facility: _____

Phone, email, or Fax: _____

What do you consider to be some of your strengths?