CLIENT INTAKE FORM

Date of first appointment: _____

Name: _____Pronouns: _____

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: _____
- ❏ Insurance Provider: _____
- ❏ Friend/Family: _____
- ❏ Other: _____
- ❏ Gregwrightpsychotherapy.com
- ❏ Psychology Today
- ❏ GoodTherapy.com

Have you previously received any type of mental health services? Yes / No
If yes, which of the following:

- ❏ Psychotherapy
- ❏ Medication
- ❏ Outpatient Hospitalizations
- ❏ Inpatient Hospitalization
- ❏ If yes, please provide:

Provider/Facility:_____Location:_____
Dates of treatment:_____Reason for treatment:_____

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

What areas of your life have been affected because of this problem? _____
_____

Are you currently experiencing overwhelming sadness, grief or depression? Yes / No
If yes, for approximately how long? _____
Are you currently experiencing anxiety, panic attacks or have any phobias? Yes / No
If yes, when did you begin experiencing this? _____
Please describe any major losses or traumas you have experienced:_____
_____
_____
_____

CLIENT INTAKE FORM

What significant life changes or stressful events have you experienced recently? _____
_____
_____
_____
What would you like to accomplish out of your time in therapy? _____
_____
_____
_____

Family History:

Where were you born? _____Where did you grow up? _____

- ❏ City
- ❏ Suburbs
- ❏ Country

Please list your parents and siblings. Please use additional space on the back if needed

Name	Age	Relationship	Where do they live now?	If deceased, age and cause of death

Who did you live with while growing up? _____
Parent #1/occupation: _____Parent #2/ occupation? _____

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

Condition	Please circle	List Family Member
Alcohol/Substance Abuse	yes/no	
Anxiety	yes/no	
Depression	yes/no	
Domestic Violence	yes/no	
Sexual Abuse	yes/no	
Eating Disorders	yes/no	
Obesity	yes/no	
Obsessive Compulsive Disorder	yes/no	
Schizophrenia	yes/no	
Suicide Attempts	yes/no	
Other diagnosed mental health condition?	yes/no	

CLIENT INTAKE FORM

Relationship Status:

- ❏ Single
- ❏ Partnered
- ❏ Polyamorous
- ❏ Married
- ❏ Separated - For how long? _____
- ❏ Divorced - For how long? _____
- ❏ Survivor: Please provide your spouse's/partner's name and year deceased: _____/_____
- ❏ If married/partnered, how long have you been in a relationship? _____
- ❏ Name(s) of Spouse/Partner(s) : _____/_____/_____

On a scale of 1-10 (best), how would you rate your relationship? _____

Please list any children, their names, and ages:

Name	Age	Relationship	Name of other parent	If deceased, age and cause of death

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: _____

CLIENT INTAKE FORM

How would you rate your current physical health?

- ❏ Poor
- ❏ Unsatisfactory
- ❏ Satisfactory
- ❏ Good
- ❏ Very Good

Please list any specific health problems you are currently experiencing:

_____

_____

_____

How would you rate your current sleeping habits?

- ❏ Poor
- ❏ Unsatisfactory
- ❏ Satisfactory
- ❏ Good
- ❏ Very Good

If you are having problems, in which phase of sleep are you experiencing issues?

- ❏ Falling asleep
- ❏ Staying asleep
- ❏ Awakening early
- ❏ Sleep apnea

Please list any other specific sleep problems you are currently experiencing:

_____

_____

_____

How many times per week do you generally exercise? _____

What types of exercise do you participate in: _____

Are you currently experiencing any chronic pain? Yes/No

If yes, please describe: _____

Please describe current use of alcohol, cigarettes, and/or recreational drugs:

_____

_____

_____

Please describe previous use of alcohol, cigarettes, and/or recreational drugs:

_____

_____

_____

CLIENT INTAKE FORM

Additional Information:

What do you enjoy about your work (full-time homemaker included)? _____

_____

_____

_____

If retired, what did you enjoy about your work? _____

_____

_____

_____

What do you find particularly stressful about your current or previous work? _____

_____

_____

_____

What do you enjoy doing in your free time? _____

_____

_____

_____

What do you do to relax? _____

_____

_____

_____

Do you consider yourself to be spiritual or religious? Yes/No | If yes, please describe:_____

_____

_____

_____

What do you consider to be some of your strengths? _____

_____

_____

_____

What do you consider to be some of your weaknesses? _____

_____

_____

_____

_____