3388 South Hull Street, Montgomery, Alabama 36105 · (334) 263-0041 · (334) 262-5091

Client Intake Form

Please provide the following information for our records. Leave blank any question you would rather not answer. Information you provide here is held to the same standards of confidentiality as our therapy. Please print out this form and bring it to your first session or allow yourself thirty minutes prior to your appointment to complete the form in the office.

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

Name of parent/guardian (if you are a minor):
_____
(Last) (First) (Middle Initial)

Birth Date: _____ /_____ /_____ Age: _____ Gender: ☐ Male ☐ Female

Marital Status: ☐ Never Married ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐Widowed

Number of Children: _____

Address: _____
(Number and Street) (City, State, Zip)

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

Cell/Other Phone: _____ May we leave a message? ☐ Yes ☐ No

E-mail: _____ May we email you? ☐ Yes ☐ No

Referred by: _____

Are you currently receiving psychiatric services, professional counseling or psychotherapy elsewhere?
☐ Yes ☐ No

Have you had previous psychotherapy? ☐Yes ☐ No

Previous therapist's name: _____

Are you currently taking prescribed psychiatric medication (antidepressants or others)?
☐Yes ☐No

If Yes, please list: _____

If no, have you been previously prescribed psychiatric medication? ☐Yes ☐No

If Yes, please list: _____

HEALTH AND SOCIAL INFORMATION

1. How is your physical health at present? ☐Poor ☐Unsatisfactory ☐Satisfactory ☐Good ☐Very good

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

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

If yes, check where applicable: ☐ Sleeping too little ☐ Sleeping too much ☐ Poor quality sleep

☐Disturbing dreams ☐ Other

4. How many times per week do you exercise? _____

Approximately how long each time? _____

5. Are you having any difficulty with appetite or eating habits? Yes No

If yes, check where applicable: ☐ Eating less ☐ Eating more ☐ Binging ☐ Restricting

Have you experienced significant weight change in the last 2 months? ☐ Yes ☐ No

6. Do you regularly use alcohol? ☐ Yes ☐ No

In a typical month, how often do you have 4 or more drinks in a 24-hour period? _____

7. How often do you engage in recreational drug use? ☐Daily ☐Weekly ☐Monthly ☐Rarely ☐Never

8. Have you had suicidal thoughts recently? □ Frequently □ Sometimes □ Rarely □ Never Have you had them in the past? ☐ Frequently ☐ Sometimes ☐ Rarely ☐ Never

9. Are you currently in a romantic relationship? ☐ No ☐ Yes

If yes, how long have you been in this relationship?

On a scale of 1-10, how would you rate the quality of your current relationship? _____

10. In the last year, have you experienced any significant life changes or stressors?

_____

Have you ever experienced: Please check all that apply

☐Extreme depressed mood:

☐Wild Mood Swings

☐Rapid Speech

☐Extreme Anxiety

☐Panic Attacks

☐Phobias

☐Sleep Disturbances

☐Hallucinations

☐Unexplained losses of time

☐Alcohol/Substance Abuse

☐Unexplained memory lapses

☐Eating Disorder

☐Frequent Body Complaints

☐Suicide Attempt

☐Body Image Problems

☐Repetitive Thoughts (e.g., Obsessions)

☐Repetitive Behaviors (e.g., Frequent Checking, Hand-Washing)

☐Homicidal Thoughts

OCCUPATIONAL INFORMATION:

Are you currently employed? ☐ No ☐ Yes

If yes, who is your current employer/position? _____

If yes, are you happy at your current position? _____

Please list any work-related stressors, if any: _____

RELIGIOUS/SPIRITUAL INFORMATION:

Do you consider yourself to be religious? ☐ Yes ☐ No

If yes, what is your faith? _____

If no, do you consider yourself to be spiritual? ☐ Yes ☐ No

FAMILY MENTAL HEALTH HISTORY:

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (Check all that apply and list family member, e.g., Sibling, Parent, Uncle, etc.):

Difficulty:

Depression:	☐ Yes ☐ No	Bipolar Disorder:	☐ Yes ☐ No
Anxiety Disorders:	☐ Yes ☐ No	Panic Attacks:	☐ Yes ☐ No
Schizophrenia:	☐ Yes ☐ No	Alcohol/Substance Abuse:	☐ Yes ☐ No
Eating Disorders:	☐ Yes ☐ No	Learning Disabilities:	☐ Yes ☐ No
Suicide Attempts:	☐ Yes ☐ No	Trauma History:	☐ Yes ☐ No

List Family Member(s)

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

OTHER INFORMATION:

What do you consider to be your strengths?

_____

What do you like most about yourself?

_____

_____

What are effective coping strategies that you've learned?

_____

_____

What are your goals for therapy?

_____

_____