660 Linton Blvd, Delray Beach, FL 33444
Appointments: 561-272-8880 | Counselingservicesassoc@gmail.com

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

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/Text:_____ May we leave a message? □ Yes □ No
Email:_____ May we email you? □ Yes □ No

Referred by:_____

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

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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 times per week do you exercise? _____days _____minutes/hours

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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

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?_____

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

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.)?

_____

_____

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Quick Check

Check the boxes of the symptoms you have experienced.

□ Extreme depressed mood	□ Mood swings	□ Rapid speech	□ Extreme anxiety
□ Panic attacks	□ Phobias	□ Disturbed sleep	□ Hallucinations
□ Memory lapse	□ Alcohol/substance abuse	□ Body complaints	□ Eating disorder
□ Repetitive thoughts	□ Anxiety	□ Time loss	□ Repetitive behaviors
□ Homicidal thoughts	□ Suicide attempts	□ Trouble planning	□ Relationship trouble

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.

Issue			*Family Member*
Depression	□ Yes	□ No	_____
Anxiety Disorder	□ Yes	□ No	_____
Bipolar Disorder	□ Yes	□ No	_____
Panic Attacks	□ Yes	□ No	_____

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Alcohol/Substance Abuse	□ Yes	□ No	_____
Eating Disorder	□ Yes	□ No	_____
Learning Disability	□ Yes	□ No	_____
Trauma History	□ Yes	□ No	_____
Domestic Violence	□ Yes	□ No	_____
Obesity	□ Yes	□ No	_____
Obsessive Compulsive Behavior	□ Yes	□ No	_____
Schizophrenia	□ Yes	□ No	_____