Client Information

Client's name: _____ Today's date: ____/____/____

Address: _____
(Street) (City) (State) (Zip)

Date of birth: ____/____/____ Gender: _____ Sexual orientation: _____

To which cultural/ethnic group(s) do you belong: _____

Occupation: _____ Employer (if applicable): _____

Phone: _____(home) _____(mobile) _____(work)

Email: _____

CONTACT INFORMATION

OK to send snail mail? ☐Yes ☐No OK to email (using encrypted Hushmail)? ☐Yes ☐No
OK to call? ☐Yes ☐No OK to leave message? ☐Yes ☐No What is the preferred number? _____

Please provide a name and phone number of whom to call in case of an emergency: _____
_____

PAYMENT INFORMATION

Private Pay: ☐Yes ☐No Fee Pay Rate: $185/50 minute intake; $150/45 minute regular session
*If not private pay, Insurance Name:_____
**You are responsible for payment of charges incurred, regardless of whether your insurance company decides to honor this claim.*
Co-pay or Co-insurance: $_____
Name of Policy Holder: _____
Birth Date of Policy Holder: _____
Address of Policy Holder: _____
Policy Holder I.D. Number: _____
Policy Holder Group Number: _____
Client Signature indicating that you understand and agree to this payment arrangement: _____
Will you be requesting a bill and/or a receipt? Is it for insurance or for a flex spending plan? (Please circle one.)

REFERRAL INFORMATION

Who referred you to me or how did you hear of my practice? _____
May I have your permission to contact this person to thank him or her for the referral? ☐yes ☐no

Current reason(s) for seeking therapy: _____
_____
_____
_____
_____
_____
_____

Please estimate the degree of difficulty experienced in each area by marking each item with the appropriate number:
1 = no difficulty 2 = mild difficulty 3 = moderate difficulty 4 = severe difficulty 5 = very severe

_____job/school _____family relationships _____friendships _____partner/relationship
_____food/body image _____violence/abuse/trauma _____alcohol/drug use
_____medical condition _____life transition(s) _____grief/loss _____sexual identity
_____other (specifically: _____)

Seeking counseling to help with (check all that apply):
☐coping ☐anxiety ☐depression ☐fear/phobias ☐eating disorder
☐sleeping problems ☐addictive behaviors ☐career concerns ☐existential concerns
☐sexual concerns ☐other (specifically: _____)

I have had an unwanted sexual experience: ☐never ☐recently ☐in the past ☐unsure
I consider my unwanted sexual experience to be: ☐rape ☐incest ☐sexual assault ☐other

I am dissatisfied with my personal appearance: ☐yes ☐no
I have tried to control my weight ☐recently ☐in the past
With: ☐vomiting ☐no eating/dieting ☐laxatives ☐excessive exercise ☐diet pills ☐diuretics

FAMILY INFORMATION

Who currently lives with you in your home or is a part of your immediate family?

Name	Age	Relationship (i.e., parent, spouse, partner, child, pet, etc.)

Is your mother still living? ☐Yes ☐No Is your father still living? ☐Yes ☐No
Are your parents (circle all that apply): Married to each other Divorced/separated Remarried Never married

Special circumstances (e.g., raised by person other than parent(s), information about spouse/children not living with you, etc.): _____

Is there any alcohol or drug abuse in your current home that concerns you? ☐Yes ☐No ☐Unsure
Is there any violence or other abuse in your current home that concerns you? ☐Yes ☐No ☐Unsure

Was there any alcohol or drug abuse in your home growing up? ☐Yes ☐No ☐Unsure
Was there any violence or physical abuse in your home growing up? ☐Yes ☐No ☐Unsure
Was there any violence or sexual abuse in your home growing up? ☐Yes ☐No ☐Unsure
Was there any verbal abuse in your home growing up? ☐Yes ☐No ☐Unsure
Other childhood circumstances (such as neglect or inadequate nutrition, trauma, frequent moves, parent death, etc.) that affected your development? _____

How would you describe your relationship with your mother? ☐Good ☐Fair ☐Poor ☐Non-existent
How would you describe your relationship with your father? ☐Good ☐Fair ☐Poor ☐Non-existent

Relationship status (more than one answer may apply):
☐single ☐legally married (for #_____yrs) ☐unmarried, living together (for #_____yrs)
☐divorce in process (length of time:_____yrs) ☐divorced (length of time:_____yrs)
☐annulment: (length of time:_____yrs) ☐widowed: (length of time:_____yrs) Total # of marriages: _____
Assessment of current relationship (if applicable): ☐good ☐fair ☐poor

SOCIAL INFORMATION

How easy it is for you to make friends? ☐very difficult ☐somewhat difficult ☐fairly easy ☐very easy
How supportive/trustworthy do you feel your friends are? ☐very ☐somewhat ☐a little ☐not at all
Check how you generally get along with other people: (check all that apply) ☐affectionate ☐aggressive
☐avoidant ☐fight/argue often ☐follower ☐friendly ☐leader ☐outgoing ☐shy/withdrawn
☐submissive ☐other (specify): _____
What do you wish were different about your friendships?_____

SPIRITUAL/RELIGIOUS

How important to you are spiritual maters? ☐not ☐little ☐moderate ☐much
Are you affiliated with a spiritual or religious group? _____ If yes, what?_____
Were you raised within a spiritual or religious group?_____ If yes, what?_____
Would you like your spiritual/religious beliefs incorporated into the counseling? If yes, describe:_____
_____

HEALTH INFORMATION

Name of your medical doctor: _____
Address of medical group: _____ Phone: _____
Name of your psychiatrist/prescriber:_____
Address of psychiatrist/prescriber: _____ Phone: _____
Have you ever been hospitalized? (If yes, please provide details):_____
_____

Are you currently taking any prescribed medications? (Please list names, dosages, frequency, and prescriber): _____
_____

Have you experienced any recent healthy or physical changes?_____
Please list any current health concerns:_____
Have you been diagnosed with a learning disability, identified as gifted, other special circumstances?_____

Have you previously participated in psychotherapy? _____
Therapist Name Location (City/State) Dates
_____
_____

Was it helpful? (Why or why not?) _____

Have you ever had thoughts of wanting to end your life? ☐yes ☐no If yes, when? _____
Have you ever had a plan as to how, when, or where you might end your life? ☐yes ☐no If yes, when? _____
Do you have any previous suicide attempts, self destructive behaviors, or violent behaviors? ☐yes ☐no
When did you have these? (indicate age, circumstances, and whether it led to hospitalization or legal problems)_____
_____
Have you ever thought about seriously harming another person? ☐yes ☐no If yes, when? _____
Have you ever attempted to physically harm someone? ☐yes ☐no If yes, when? _____

Please list any past drug and alcohol use. What have you used and how much? _____
_____
The following has resulted from my use of alcohol/drugs: ☐traffic ticket/violation ☐ruined relationship
☐black outs ☐fight with friend ☐problems with school/job ☐difficulties with memory
What are you currently using and how much? _____
What is the frequency of use? ☐several times per week ☐weekly ☐monthly ☐less than once per month

Have any family members been diagnosed and/or treated for mental or emotional conditions? ☐yes ☐no ☐unsure
If yes, please explain: _____

OTHER

What do you consider your main strengths?

What special areas of interest, activities or hobbies do you enjoy?

How often do you participate in/do the above now vs. in the past?

What are your primary challenges right now?

What are your most important hopes or dreams?

Please add any additional information that may be helpful to our work together.