TheTherapyDr.

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Client Intake Form

Name: _____ Date: _____DOB: ____/_____/_____ Age: _____

Address:_____

City/State:_____ ZIP: _____

Cell #: _____ Work #: _____

Employer: _____ Profession/Occupation_____

Previous Counseling/Therapy? Yes No If Yes, when & duration? _____

Does anyone in your family have any history of mental illness (such as depression, anxiety, substance abuse, etc.)? If so, please list _____

Poor Excellent How do you sleep at night? 1 2 3 4 5 How is your nutrition? 1 2 3 4 5

Do you drink alcohol? Yes/ No How much? _____
Do you drink coffee? Yes/ No How much? _____
Do you smoke cigarettes? Yes/No How much? _____
Does any of the following items apply to your concern today?

_____Anger/temper _____Multicultural issues _____Problems with social relationships
_____Anxiety _____Depression _____Sexual Abuse/Trauma
_____Family or business consultation _____Sexual Concerns/Dysfunction
_____Fearfulne _____Life stage issues _____Thoughts of hurting yourself or others

_____Trouble making decisions _____Marital issues _____Other (Specify)_____

Brief summary of reason for seeking treatment: _____

_____

Whom were you referred by? _____

Signature_____Date_____