

CLIENT INTAKE FORM

Briefly describe why you are seeking help: \_\_\_\_\_

\_\_\_\_\_

Briefly describe the goals you want to accomplish from your session experience.

\_\_\_\_\_

\_\_\_\_\_

List medication you are presently taking: \_\_\_\_\_

\_\_\_\_\_

Are you currently seeing another therapist or a doctor? \_\_\_\_\_

Do you have a psychological diagnosis? \_\_\_\_\_

If yes, what? \_\_\_\_\_

\_\_\_\_\_

Do you have heart problems? If so, please explain: \_\_\_\_\_

\_\_\_\_\_

List and other diagnosed physical problems: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Are you prone to seizures? \_\_\_\_\_ Migraines? \_\_\_\_\_

Are you pregnant? \_\_\_\_\_ If so, how many months? \_\_\_\_\_

**PLEASE UNDERLINE THOSE PROBLEMS WHICH PERTAIN TO YOU:**

Alcohol Use	Drug Use	Marriage	Sexual Problems	Unhappy
Ambition	Education	Nervousness	Shame/Guilt	Weight
Anger	Fears	Nightmares	Shyness	
Bed Wetting	Finances	Panic Attacks	Sleep Problems	
Bowel Problems	Friends	Parenting	Smoking	
Career	Headaches	Phobia	Stress	
Children	Health	Problems/Appetite	Suicidal Thoughts	
Depression	Inferiority	Problems /Memory	Temper	
Dishonesty	Legal Events	Self-Control	Tension	
Divorce	Loneliness	Self-Image	Tired	

Other: \_\_\_\_\_

\_\_\_\_\_