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www.supportforlifetherapy.com

New Client form 5 (on website)

Therapy Intake form

Note: This information is confidential. If you are completing this form prior to your first appointment, please bring this form with you.

Relationship Status: # of Children/Ages:

Race/Ethnicity: Religious/Spiritual Faith:

What brings you to therapy at this time?

Please rate the level of stress you are currently experiencing on a daily basis? (1 = none, 10 = severe):

What do you hope to get out of therapy? (e.g., if therapy succeeds, what will be different?)

Have you been in therapy before?
yes / no If yes, please give dates and explain how helpful (or not helpful) this was:

Please answer the following questions using:
5 Excellent, 4 Good, 3 Average, 2 Poor, 1 Failing
(if does not apply to you, please use N/A)

How would you currently rate your physical health: _____

How would you currently rate your mental health: _____

How would you currently rate your spiritual health: _____

How would you currently rate the health of your relationships: _____

With respect to the above responses, please explain areas of concern:

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Please list and where necessary explain/describe any health/medical issues you are living with?

Name of Primary Care Physician: _____

Physician Phone #: _____

Address: _____

_____

Please list any prescription medications you are currently taking:

Please list any over the counter medications, vitamins, or herbal supplements you are currently taking:

Do you currently exercise?
yes / no If yes, please indicate how many times per week:

Please indicate substances currently used (over the past 6 months) and the frequency:

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Have you ever had problems with work, relationships, health, the law, etc. due to your substance use?
yes / no If yes, please describe:

Does anyone you live with currently have a problem with substances?
yes / no If yes, please explain who and what the issue is:

When you were growing up, were there any problems with substance abuse in your family?
yes / no If yes, please describe:

Are you currently receiving some kind of mental health services?
yes / no If yes, please list name of practitioner and type of services you are receiving:

Have you ever been diagnosed with a mental illness?
yes / no If yes, please list illness(es) and date(s) first diagnosed:

Has anyone in your family ever been diagnosed with a mental illness?
yes / no If yes, please list relationship(s) and diagnosis:

Have you ever had suicidal or homicidal thoughts?
yes / no If yes, please explain:

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Have you ever attempted suicide?
yes / no If yes please list date(s), your age at time of attempt(s) and what happened:

Have you ever been depressed for a significant length of time?
yes / no If yes, please describe:

Have you ever experienced overwhelming levels of anxiety or panic?
yes / no If yes, please describe:

Do you have any obsessive thoughts/behaviors that influence the quality of your life?
yes / no If yes, please describe what and how:

Do you currently or have you ever had trouble sleeping?
yes / no If yes, please describe:

Are you currently having, or have you ever had any problems related to money, spending, gambling, credit cards or finances?
yes / no, If yes, please describe:

Do you currently or have you ever had problems with eating or with food?
yes / no If yes, please describe:

Do you have any concerns related to your weight and/or physical appearance?
yes / no If yes, please describe:

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Have any aspects of your sexuality ever been a cause of concern for you?
yes / no If yes, please describe:

Please describe what, if any experience you have had with any physical or sexual violence/abuse (as a victim, witness, or perpetrator)?

Please feel free to share any additional comments or concerns: