

# New Client Intake Form

*Please fill out this biographical background form as completely as possible for each person in therapy. This information, like our therapy sessions, is confidential. Please print or write clearly and bring it with you to our first meeting.*

**Today's date:** \_\_\_\_\_

**Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

\_\_\_\_\_ **Zip:** \_\_\_\_\_

**Date and place of birth:** \_\_\_\_\_ **Age:** \_\_\_\_\_

**Telephone:** *Please star the number you want used for private messages.*

**Home** \_\_\_\_\_

**Cell** \_\_\_\_\_

**Work** \_\_\_\_\_

**Email:** \_\_\_\_\_

**Referral Source:** \_\_\_\_\_

**Person and phone # to call in emergency:** \_\_\_\_\_

**Members of household:**

\_\_\_\_\_ **Age:** \_\_\_\_\_

\_\_\_\_\_ **Age:** \_\_\_\_\_

\_\_\_\_\_ **Age:** \_\_\_\_\_

\_\_\_\_\_ **Age:** \_\_\_\_\_

\_\_\_\_\_ **Age:** \_\_\_\_\_

**Highest educational degree:** \_\_\_\_\_

**Occupation:** \_\_\_\_\_

**Presenting problem:** *Please be as specific as you can. What brings you to therapy?  
When did it start? How does it affect you? Who is involved?*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*How severe is the problem?* mild \_\_\_ moderate \_\_\_ severe \_\_\_ very severe \_\_\_

**Resources:** *things, places relationships or activities that*

1. *calm you down* \_\_\_\_\_

2. *engage you* \_\_\_\_\_

3. *bring you pleasure* \_\_\_\_\_

4. *help you sleep* \_\_\_\_\_

When you have a good day, what makes it better than other days? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Weekly activity level: *sports, home life, work requirements* \_\_\_\_\_

**Current relationship status:** single \_\_\_ married \_\_\_ divorced \_\_\_ separated \_\_\_ partnered \_\_\_

Name: \_\_\_\_\_ Years together: \_\_\_\_\_

**Partner or spouse's education level:** \_\_\_\_\_ **Occupation:** \_\_\_\_\_

**Sexual orientation:** heterosexual \_\_\_ gay \_\_\_ lesbian \_\_\_ bisexual \_\_\_ other \_\_\_\_\_

**Past partnerships/marriages:** *Years together, names & statement about the nature of the relationship.*

---

---

---

**Children:** *Include step-, grand-, adopted and children by birth. Names, ages & brief statement on your relationship. If adopted, at what age was child placed? Domestic or foreign adoption? Open or closed adoption?*

---

---

---

---

---

**Parents:** *Name, age; if deceased, year and cause of death, occupation, personality. Brief statement about the relationship.*

**Father:** \_\_\_\_\_

---

---

**Mother:** \_\_\_\_\_

---

---

**Step-parents and/or birth parents:** \_\_\_\_\_

---

---

**Siblings:** *Name and age; if deceased, age and cause of death. Brief statement about the relationship*

---

---

---

---

**Ethnic/Cultural Heritage:** \_\_\_\_\_

---

**Spiritual perspective, practice:** \_\_\_\_\_

---

**Current physicians:** *Names and phone #s*

---

---

---

**Past and present medical care:** *Significant medical problems, surgeries, accidents, falls, illnesses.*

---

---

**Specify all medications you are presently taking, dosage and frequency:**

---

---

---

**Alcohol, drug, caffeine, and/or tobacco use:** \_\_\_\_\_

---

---

**Sleep issues:** \_\_\_\_\_

---

**Family medical history:** *Describe any illness that runs in the family.*

---

---

**Please describe any reproductive losses:** *Infertility, miscarriage, fetal demise, abortion.*

---

---

---

**Friendships, community:** *Describe quality, frequency of contact, activities.*

---

---

---

**Past psychotherapy or treatment:** *Specify patient name, duration, month & year, estimated # of sessions, therapist's name & phone #, reason for therapy, medication, brief description of the relationship, and how helpful it was and how/why it ended.*

---

---

---

---

---

---

**Describe your childhood in general:** *Relationships with parents, siblings, others, school, neighborhood, relocations, any school/behavioral problems, abusive/alcoholic parents.*

---

---

---

---

---

**If parents divorced, your age at the time:** \_\_\_\_\_. *Describe how it affected you at the time.*

---

---

---

**Family history of alcoholism, mental illness or violence:** *Include suicide, depression, anxiety, loss, grief, psychiatric hospitalization, abuse.*

---

---

---

**What gives you the most pleasure or joy in your life?** \_\_\_\_\_

**What do you do to relax, have fun, take care of yourself:** \_\_\_\_\_

---

---

**What are your main worries and fears?** \_\_\_\_\_

---

---

**What are your most important hopes or dreams?** \_\_\_\_\_

---

---

*Please add on a separate page any other information you would like me to know about you and your situation.*