Updated 10/18

Schwartz Therapy + Wellness, P.C.
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Client Intake Form

Name: ____ Age: ______

Birth Date: ___________________ E-Mail address: ______________________________

Phone Numbers: Home: ___________________ OK to leave message? _______
Work: ___________________ OK to leave message? _______
Cell: ___________________ OK to leave message? _______

How did you find out about Schwartz Therapy + Wellness, P.C.? ____________________
____

Other Family Members Attending: ____
____

Address: ____

Residence (circle): Own Home/ Apartment Rent Home/ Apartment Live With Parents Dorm Other: _____________

Current Relationship Status (circle): Single Engaged Married Remarried Separated Divorced Widowed Living Together Other:______________________

Length of Time in this Relationship Status: ______________________________

Spouse/ Significant Other's Name: ______________________________ Age: _______

Have you had any previous marriages? _______ From: _______________ to: ___________________

Current Household Members: list all persons with whom you currently live. Please indicate their name, sex and relationship to you (spouse, significant other, child, parent, sibling, etc.). Put an asterisk * next to any person you currently have a concern about.
____
____
____
____

Overall impression of your present family life: ____

____

____

Father's Name: ____ Age: ________

If deceased, date of death: _________________ How old were you at the time? _____

Mother's Name: ____ Age: ________

If deceased, date of death: _________________ How old were you at the time? _____

Siblings: Please list the name, sex, and age of all your brothers + sisters.

____

____

____

____

Overall impression of your childhood family life: ____

____

Are you currently working? ___________ Please, describe: _________________________________

How satisfied are you with your job? ____

What is the highest level of education you have completed? ____________________________

Are you planning any further education? ________If so, please specify_____________________

Describe if + how religion/ spirituality play a part in your life: ______________________________

____

List activities that you enjoy: ____

____

What do you see as your strengths? ____

____

What do you see as your weaknesses? ____

____

What are your main fears? ____

____

What are your major life goals at this time? ____

____

Do you or any members of your family suffer from alcohol or substance abuse? ____________

If yes, please describe: ____

Do you or any members of your family have a history of mental illness? ___________________

If yes, please describe: ____

Have you ever had suicidal thoughts/ attempts? ____________ When? ______________________
Please, add any information you think is important about it: ______________________________
____
**Therapist response: ____

Has anyone in your family or close circle of friends had suicidal thoughts/ attempts, or has anyone you know suicided? ____
**Therapist response: ____

List any serious illnesses, accidents, operations, or traumatic experiences (such as physical or sexual abuse) you have ever had + your age at that time: ______________________________
____
____
**Therapist response: ____

Date of last physical exam? _____________________________ Findings: ________________________

Please, list your current medications/ supplements: ____
____

Are you being seen by any other professional person (physician, minister, priest, rabbi, psychologist, social worker, etc.) for physical or emotional difficulties at this time? ___________
If yes, please describe the nature of the problem and their treatments: ____________________
____

Why did you decide to enter counseling at this time? ______________________________________

Have you had previous counseling? _________ If yes, approximately when? ________________

How would you describe your counseling experience? ____________________________________

How will you measure the success of your counseling experience with Schwartz Therapy + Wellness, P.C.? ____
____

Please, provide an emergency contact____
Relationship: _____________________________________ Phone: _____________________________

____ ____________________
Client Signature Date

I have reviewed the contents of this form + have discussed the same with the client.

____ ____________________
Therapist Date