Albuquerque Emotional Wellness
Client Intake Form

Please fill out this intake form and bring it to your first therapy session. All responses are confidential.

Name:
_____
(Last) (First) (Middle Initial)

Address:
_____
(Street and Number)
_____
(City) (State) (Zip)

Birth Date: _____ /_____ /_____

Age: _____ Gender: □ Male □ Female

Emergency contact:
Name_____ Phone: (___)_____

Marital Status:
□ Never Married □ Domestic Partnership □ Married
□ Separated □ Divorced □ Widowed

Referred by (if any): _____

Please list any children/age:
_____
_____

Home Phone: (___)_____ May we leave a message? □ Yes □ No

Cell/Other Phone: (___)_____ May we leave a message? □ Yes □ No

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?
□ No
□ Yes, previous therapist/practitioner or psychiatric hospitalization:
_____
_____
_____

Are you currently taking any prescription medication?
□ Yes
□ No
If yes, please list:
_____
_____

Have you ever been prescribed psychiatric medication?
□ Yes
□ No
Please list and provide dates:
_____

What vitamins or other supplements do you take?
_____
_____
_____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. Please list any specific health problems you are currently experiencing:
_____
_____
_____
_____

2. How many hours of sleep do you get a night, on average?_____
Please list any specific sleep problems you are currently experiencing or contributing factors to you not getting the sleep you desire:
_____
_____
_____

3. How many times per week do you generally exercise? _____
What types of exercise to you participate in?
_____
_____

4. Please list any difficulties you experience with your appetite or eating patterns:
_____
_____

5. Are you currently experiencing overwhelming sadness, grief, or feelings of hopelessness?
□ No
□ Yes
If yes, for approximately how long? _____

6. Are you currently experiencing anxiety, panic attacks, or have any phobias?
□ No
□ Yes
If yes, for approximately how long? _____

7. Are you currently experiencing any chronic anger problems?
□ No
□ Yes
If yes, please describe:
_____
_____
_____

8. If you drink alcohol, how many drinks do you consume per week?_____

9. Do you engage recreational drug use? □ No □ Yes

10. Do you experience chronic pain? □ No □ Yes If yes, please describe

_____
_____
_____ _____

11. What significant life changes or stressful events have you experienced recently?
_____
_____
_____

12. Name of primary care doctor_____ Phone (___)_____
May we contact them? □ No □ Yes

13. Name of psychiatric care doctor or nurse, if applicable
_____Phone (___)_____
May we contact them? □ No □ Yes

FAMILY MENTAL HEALTH HISTORY:
In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

Please circle, then list family member:

Alcohol/Substance Abuse yes/no _____

Anxiety yes/no _____

Bipolar Disorder yes/no _____

Depression yes/no _____

Domestic Violence yes/no _____

Eating Disorders yes/no

Obsessive Compulsive Behavior yes/no _____

Schizophrenia yes/no _____

Other _____ yes/no _____

ADDITIONAL INFORMATION:

1. Are you currently employed? □ No □ Yes
If yes, who is your employer?
_____

How many hours a week do you work?_____

Do you enjoy your work? Is there anything stressful about your current work?
_____
_____

2. Do you consider yourself to be spiritual or religious? □ No □ Yes

3. Please briefly list the goals you have for therapy below.

_____
_____
_____
_____
_____