



CLIENT INTAKE FORM

This information will accelerate our work and help us identify areas of your life that need special attention. If there are any questions you would rather not answer, please leave them blank. The information you provide here is held to the same standards of confidentiality as our therapy.

IDENTIFYING INFORMATION

Today's date _____

Name (legal): _____

Preferred name: _____

Birthday: _____

Current age: _____ Gender: _____

Marital/Partnership Status _____

Mailing Address: _____

Phone Number(s): _____ OK to leave message? _____

Email: _____

How do you prefer to be contacted by me? (phone, text message, email, mail):

Emergency Contact: _____ Relationship: _____

Phone _____

How did you hear about me: _____



CURRENT SITUATION

Present challenges that bring you to therapy:

Events that led to you seeking support:

Recent life changes or stressors:

Intentions/goals for therapy:

BACKGROUND

Developmental History:

What do you know (if anything) about the months when your mother was pregnant with you and your birth?

How would you describe your childhood/middle-school/adolescent years?

Tell me about the family system in which you were raised: (e.g. with parents, married or divorced, siblings, extended family, etc). Please include names.

How would you describe the family environment in which you grew-up? (e.g. peaceful, loving, supportive, hostile, chaotic, violent, etc)

Medical History:

Please list any current or past medical conditions or concerns you have:

Please list any current medications and dosage:

Please describe any history of head injury:

Have you ever had your thyroid checked? When/how often?

Do you currently use alcohol or drugs? If so, what type, how much and how often?

Have you ever been in treatment for substance use? If so, please explain.

Do you have any history of compulsive behaviors, such as gambling, shopping, internet use, exercise, eating, sexual behavior, etc? If so, please explain.

Educational History:

Do/did you enjoy school? Why or why not?

What are/were your favorite subjects? Why?

Is/was there anything unusual about your educational experience? (gifted or talented classes, learning disability, etc)

Highest level of education:

Educational goals:

Occupational History:

Are you currently employed? If so, where and what is your position?



How do you feel about your current job?

Occupational goals:

Spiritual Orientation:

Were you raised with a religious/spiritual orientation? If so, please describe:

Describe your current religious/spiritual affiliation and practices (if any), and their significance to you:

Social History:

To whom were you closest as a child, explain:

Were you shy or outgoing as a child? How are you now?

Please describe your current friendships:

How do you feel about the quality of your friendships?

How do you typically meet friends?

Have you experienced any significant losses (e.g., death of a loved one, moving, end of a significant relationship, etc)? If so, please provide a short description and your age at the time.

Who do you currently live with? How would you describe the environment in your home at this time?

Are you currently in a romantic relationship? If so, please provide name, age and length of relationship.

How would you describe the quality of your current relationship?

Please list previous significant relationships and durations:

How do you typically meet your romantic partners?

How would you describe your sexual orientation:

Attracted to men / masculinity 0 1 2 3 4 5 6 7 8 9 10 Attracted to women / femininity

Please list the names, ages, custody status and locations of your children (if any):

Trauma History:

Please mark any that apply to you and your best estimate of how old you were.

<u>Event:</u>	<u>Your age at the time:</u>
Physical abuse / assault	yes/no
Verbal abuse	yes/no
Emotional abuse	yes/no
Sexual abuse / assault	yes/no
Sexual harassment	yes/no
Hate crime	yes/no
Full anesthesia surgery	yes/no
Drug overdose	yes/no
Abortion	yes/no
High speed accident (car, bike, ski, etc)	yes/no
Natural disaster (flood, earthquake, etc)	yes/no
Other:	yes/no

How have the events you marked above impacted you?

Mental Health History:

Has anyone in your family experienced difficulties with the following? (mark any that apply and list family member, e.g., Mother/Father, Brother/Sister, Aunt/Uncle, Grandparent, etc.):

<u>Difficulty</u>	<u>Family Member</u>
Depression	yes/no
Bipolar Disorder	yes/no
Anxiety Disorders	yes/no
Panic Attacks	yes/no
Schizophrenia	yes/no
Alcohol/Substance Abuse	yes/no
Eating Disorders	yes/no
Learning Disabilities	yes/no
Trauma History	yes/no
Suicide Attempt	yes/no
Other:	yes/no

How have the items you marked above impacted you?



Have you ever experienced

Your age at time:

Wild mood swings	yes/no
Extreme depressed mood	yes/no
Extreme anxiety	yes/no
Panic attacks	yes/no
Phobias	yes/no
Sleep disturbances	yes/no
Hallucinations	yes/no
Unexplained losses of time	yes/no
Unexplained memory lapses	yes/no
Alcohol/Substance abuse	yes/no
Frequent body complaints	yes/no
Eating disorder	yes/no
Body image problems	yes/no
Repetitive thoughts (obsessions)	yes/no
Repetitive behaviors (frequent checking, hand-washing)	yes/no
Homicidal thoughts	yes/no
Self-harm (cutting, burning, etc)	yes/no
Suicide attempt	yes/no
Infectious disease (HIV, hepatitis, etc)	yes/no
Other:	yes/no

How have the events you marked above impacted you?

Mark any you are currently concerned about:

Addictions, substance use	Memory problems
Anger, rage, hostility, irritability	Menstrual problems, PMS, menopause
Anxiety, nervousness, racing thoughts	Mood swings
Attention, concentration, distractibility	Motivation
Body image problems	Sensitivity to rejection or criticism
Childhood issues (your own)	Panic or anxiety attacks
Cultural problems	Parenting, child rearing
Decisions, indecision	Perfectionism
Delusions (false ideas), suspiciousness	Procrastination, avoidance
Depression, sadness, crying	Relationship problems, infidelity, affairs
Domestic violence	School problems
Eating problems: overeating, under-eating, appetite, weight, nutrition	Self-esteem, feelings of inferiority
Emptiness, lack of meaning	Self-neglect, poor self-care
Fatigue, tiredness, low energy	Sexual orientation, gender identity
Fears, phobias	Shyness, social anxiety
Financial problems, debt, spending	Sleep problems
Grief, mourning, losses	Temper, aggression, violence
Guilt, shame	Thought disorganization, confusion
Impulsiveness, risk taking, loss of control	Withdrawal, isolating
Job problems	Other:
Legal problems	Other:

How are the concerns you marked above currently impacting you?

About Counseling:

Have you ever been in counseling? If so, when, and for how long?

If so, what brought you to counseling?

How was your experience(s) with counseling? What worked? What did not?

How / why did the counseling relationship end?

Have you ever experienced body-centered psychotherapies? If so, how was that for you?

Are you interested in exploring body-centered psychotherapy? Why or why not?

Sometimes, the Hakomi method of body-centered psychotherapy involves the use of non-sexual touch by me. Please tell me how this sounds to you:



Have you ever experienced nature-based therapy? What are your feelings towards nature?

Are you interested in exploring your challenges through nature, art, and other creative processes?
Why or why not?

Do you have any allergies I should be aware of? (insects, pollen, art materials, etc)

How do you feel about “getting messy”? (with art materials, clay, dirt, etc)

Do you have any sensory (tactile) differences or challenges? If so, please explain.

Other Information that Will Assist Us in Your Therapy:

What do you consider to be your strengths and weaknesses?

What do you like most about yourself?

What are effective coping strategies that you've learned? When and how do you use them?



What do you do for fun, self-care, self-expression?

Anything else that would be helpful for me to know about you?