



Client Intake Form

Please provide the following information for our records. Leave blank any question you would rather not answer, or would prefer to discuss with one of us in person. Information you provide here is held to the same standards of confidentiality as our encrypted sessions.

DEMOGRAPHIC INFORMATION

Name (first, last) Birthdate

Gender female male other proper pronoun

Mailing address
street address, apt# City ST zip code

Email address

Cell phone# Receive texts? yes no

Emergency contact person their ph#
 relationship to you their email

Referred by (or how did you hear of us?)

TREATMENT HISTORY

Is this your first time trying psychosociotherapy? no yes

If not, who was your previous psychosociotherapist?

How would you rate this experience?

Extremely helpful	Moderately helpful	Inadequate for my need(s)	Painful mistake	Abruptly quit
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Have you had previous psychotherapy? no yes

If yes, who, and where?

How would you rate this experience?

Extremely helpful	Moderately helpful	Inadequate for my need(s)	Painful mistake	Abruptly quit
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Are you currently receiving psychiatric services, professional counseling or psychotherapy elsewhere? no yes

If yes, who, and where?

How would you rate this experience?

Extremely helpful	Moderately helpful	Inadequate for my need(s)	Painful mistake	Abruptly quit
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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Value Relating intake form

Are you currently taking prescribed psychiatric medication (antidepressants or others)? yes no

If yes, please list the med, and prescribed by:

medication name	prescribed by

HEALTH INFORMATION

Do you currently have a primary physician? yes no

If yes, who is it?

Are you currently seeing more than one medical health specialist? yes no

If yes, please list

When was your last physical? within the last year over a year ago cannot recall

Are you currently experiencing any physical symptoms or health concerns? (e.g., chronic pain, headaches, hypertension, diabetes, etc.) yes no

If yes, please list

Are you currently on medication to manage a physical health concern? yes no

If yes, please list

Are you currently enduring health concerns for lack of competent care or funding? yes no

If yes, please list

Are you having any problems with your sleep habits? yes no

If yes, sleeping too little? yes no If yes, poor quality of sleep? yes no

If yes, sleeping too much? yes no If yes, disturbing dreams? yes no

Other:

How many times per week do you exercise? Approximately how long each time?

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Value Relating intake form

What, if any, disabilities do you have? _____

Are you on any disability income? yes yeah, but about to lose it applied for no

Are you having any difficulty with appetite or eating habits? yes no

If yes, eating less? yes no If yes, binge eating? yes no

If yes, eating more? yes no If yes, restricting from eating yes no

Have you experienced significant weight change in the last 2 months? yes no

Do you regularly use alcohol? (regularly = at least 1 drink per day) yes no

In a typical month, how often do you have 4 or more drinks in a 24-hour period? _____

Do you smoke cigarettes or use other tobacco products? yes no

How often do you engage in recreational drug use?

	daily	weekly	monthly	rarely	never
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Have you had suicidal thoughts recently?

	frequently	sometimes	rarely	never
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Have you had suicidal thoughts in the past?

	frequently	sometimes	rarely	never
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If any suicidal attempts, when was your last try? (leave blank if never attempted suicide)

	within last 24 hours	within the last week or month	over a month ago	over a year or more
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Have you ever experienced any of the following?

Extreme depressed mood	<input type="checkbox"/> yes	<input type="checkbox"/> no
Dramatic mood swings	<input type="checkbox"/> yes	<input type="checkbox"/> no
Rapid speech	<input type="checkbox"/> yes	<input type="checkbox"/> no
Extreme anxiety	<input type="checkbox"/> yes	<input type="checkbox"/> no
Panic attacks	<input type="checkbox"/> yes	<input type="checkbox"/> no
Phobias	<input type="checkbox"/> yes	<input type="checkbox"/> no
Sleep disturbances	<input type="checkbox"/> yes	<input type="checkbox"/> no
Hallucinations	<input type="checkbox"/> yes	<input type="checkbox"/> no
Unexplained losses of time	<input type="checkbox"/> yes	<input type="checkbox"/> no
Unexplained memory lapses	<input type="checkbox"/> yes	<input type="checkbox"/> no
Alcohol/substance abuse	<input type="checkbox"/> yes	<input type="checkbox"/> no
Frequent body complaints	<input type="checkbox"/> yes	<input type="checkbox"/> no
Eating disorder	<input type="checkbox"/> yes	<input type="checkbox"/> no
Body image problems	<input type="checkbox"/> yes	<input type="checkbox"/> no
Repetitive thoughts (e.g. obsessions)	<input type="checkbox"/> yes	<input type="checkbox"/> no
Repetitive behaviors (e.g. frequent checking, hand washing)	<input type="checkbox"/> yes	<input type="checkbox"/> no
Homicidal thoughts	<input type="checkbox"/> yes	<input type="checkbox"/> no

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RELATIONSHIP INFORMATION

Are you currently in a yes complicated no If yes, how long have you been in this relationship?

On a scale of 1-10 (10 being the highest quality), how would you rate your current relationship?

Do you have anyone in your life you can call during an emotional crisis? yes maybe no If yes, when was the last time you were helped through a crisis by this person?

On a scale of 1-10 (10 being the highest quality), how would you rate their trustworthiness now?

Starting with the family member who has had the most impact upon your life, provide the following information for each.

Relative 1 (name) Have their ph#? no yes

If yes, relation (e.g., sister stepfather, grandmother)

How would you rate their current relationship with you?	Faithfully supportive <input type="checkbox"/>	Unreliably supportive <input type="checkbox"/>	Apathetic to my need(s) <input type="checkbox"/>	Persistently intimidating <input type="checkbox"/>	No longer in my life <input type="checkbox"/>
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Relative 2 (name) Have their ph#? no yes

If yes, relation (e.g., sister stepfather, grandmother)

How would you rate their current relationship with you?	Faithfully supportive <input type="checkbox"/>	Unreliably supportive <input type="checkbox"/>	Apathetic to my need(s) <input type="checkbox"/>	Persistently intimidating <input type="checkbox"/>	No longer in my life <input type="checkbox"/>
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Relative 3 (name) Have their ph#? no yes

If yes, relation (e.g., sister stepfather, grandmother)

How would you rate their current relationship with you?	Faithfully supportive <input type="checkbox"/>	Unreliably supportive <input type="checkbox"/>	Apathetic to my need(s) <input type="checkbox"/>	Persistently intimidating <input type="checkbox"/>	No longer in my life <input type="checkbox"/>
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Relative 4 (name) Have their ph#? no yes

If yes, relation (e.g., sister stepfather, grandmother)

How would you rate their current relationship with you?	Faithfully supportive <input type="checkbox"/>	Unreliably supportive <input type="checkbox"/>	Apathetic to my need(s) <input type="checkbox"/>	Persistently intimidating <input type="checkbox"/>	No longer in my life <input type="checkbox"/>
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Relative 5 (name) Have their ph#? no yes

If yes, relation (e.g., sister stepfather, grandmother)

How would you rate their current relationship with you?	Faithfully supportive <input type="checkbox"/>	Unreliably supportive <input type="checkbox"/>	Apathetic to my need(s) <input type="checkbox"/>	Persistently intimidating <input type="checkbox"/>	No longer in my life <input type="checkbox"/>
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Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (check any that apply and list family member, e.g. sister, parent, uncle, etc.)

Difficulty	<input type="checkbox"/> yes	<input type="checkbox"/> suspect	<input type="checkbox"/> no	Family member
Extreme depressed mood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Bipolar disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Anxiety disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Panic attacks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Schizophrenia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Alcohol/substance abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Eating disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Learning disabilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Trauma history	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Suicide attempts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Chronic illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

In the last year, have you experienced any significant life changes or stressors? yes no

If yes, please explain:

What role if any did your listed relatives above play in this significant life changing event/stressor?

Relative	critically supported	minimally supported	abandoned	main stressor	cut off contact
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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INCOME-SOURCE INFORMATION

Are you currently employed? yes no

If yes, who is your current employer/position?

	Very satisfied	Moderately satisfied	Neither satisfied nor dissatisfied	Moderately dissatisfied	Very dissatisfied
If yes, are you happy with your current position?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Is your current job your primary source of income?	<input type="checkbox"/> yes <input type="checkbox"/> no	If no, does public assistance cover most of your living costs?	<input type="checkbox"/> yes <input type="checkbox"/> no
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If neither, how do you cover your living costs?

How effective or powerless do you feel in relation to your income source(s)?	confidently effective	increasingly assertive	never think about it	mostly helpless	utterly powerless
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

How do you handle a dispute with your source of income? (pick option that best fits your actual behavior)	avoid any conflict with them	discuss with others to try to get over it	never had any dispute with them	use official grievance process	find common ground to solve it
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Can you picture yourself confronting your income source on your own to deal with a conflict?	yes, I clearly can	in the right conditions	too nervous to try	highly unlikely	definitely not
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

RELIGIOUS/SPIRITUAL INFORMATION

Do you consider yourself to be religious? yes no

If yes, what is your current faith?

If no, do you consider yourself to be spiritual? yes no

Are you in regular contact with others of your faith or spirituality? yes no

If yes, do you consider them a source of support to face life's challenges? yes no

If you trust them to support you during life's challenges, how would you rate their helpfulness?	overbearing	paternalistic	meaningful	disappointing	nonexistent
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Which statement best captures how you perceive others' regard toward you when you're in dire need?	supported to the point of feeling smothered	mostly supported	free to be me and still be supported	mostly on my own	entirely alone against the world
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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OTHER INFORMATION

What is your highest level of education?	GED (or less)	high school diploma	some college/ vocational ed	college degree	post graduate degree
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

What is the best thing that has happened in your life so far?

What would you say is your purpose in life? (You can leave blank if your mind draws a blank.)

What do you consider to be your most remarkable qualities?

What do you like most about yourself?

What do you like least about yourself?

What are some effective coping strategies that you have learned?

What would you say is your worst fear about psychotherapy, if any?

Add something about yourself that this form didn't cover, so we can better serve you.

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YOUR SITUATIONAL NEEDS

If seeking *trans-economic support*, list any economic-related stressors (e.g., overbearing boss, fear of job loss, risk of foreclosure, student loan default, loss of government benefits, etc.)

If seeking *trans-judicial support*, list any judicial-related stressors (e.g., collateral consequences of conviction allowing legally privileged discrimination in employment, housing, education, etc.)

If seeking *trans-political support*, list any political-related stressors (e.g., political polarization resulting in losing family member connections, losing friends over politics; overwhelmed by biased media coverage, etc.)

YOUR EXPECTATIONS

What are your current goals for therapy? (You can wait to complete this for when we meet.)

1	
2	
3	
4	
5	

FINISH & SEND

When done, save this document. Then return it by email to valuerelating@protonmail.com, with message title: intake assessment. We can review it the next time we meet, and explore other things if you so wish.

Your name:

Your email address:

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Thank you for letting us serve you.

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