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 |  |

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| --- | --- | --- | --- | --- |
| 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 |
|   |   |  |   |  |

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| --- | --- | --- |
| 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 |
|   |   |  |   |  |

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| --- | --- | --- |
| 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 |
|   |   |  |   |  |

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| --- | --- | --- |
| 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 |
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# HEALTH INFORMATION

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| --- | --- |
| Do you currently have a primary physician? |  yes  no |
| If yes, who is it? |  |

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| --- | --- |
| Are you currently seeing more than one medical health specialist? |  yes  no |
| If yes, please list |  |
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| 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 |  |
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| Are you currently on medication to manage a physical health concern? |  yes  no |
| If yes, please list |  |
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| --- | --- |
| Are you currently enduring health concerns for lack of competent care or funding? |  yes  no |
| If yes, please list |  |

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| --- | --- |
| 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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| --- | --- |
| 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 |

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| --- | --- |
| 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? |  |

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

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| --- | --- | --- | --- | --- | --- |
| How often do you engage in recreational drug use? | daily | weekly | monthly | rarely | never |
|   |   |  |   |  |

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| --- | --- | --- | --- | --- |
| Have you had suicidal thoughts recently? | frequently | sometimes | rarely | never |
|   |   |  |   |
| Have you had suicidal thoughts in the past? |   |   |  |   |
| 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 |
|   |   |  |   |

Have you ever experienced any of the following?

|  |  |
| --- | --- |
| Extreme depressed mood |  yes  no |
| Dramatic mood swings |  yes  no |
| Rapid speech |  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 (e.g. obsessions) |  yes  no |
| Repetitive behaviors (e.g. frequent checking, hand washing) |  yes  no |
| Homicidal thoughts |  yes  no |

# RELATIONSHIP INFORMATION

|  |  |  |  |
| --- | --- | --- | --- |
| Are you currently in a romantic relationship? |  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? |  |

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| --- | --- | --- | --- |
| 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 | Unreliably supportive | Apathetic to my need(s) | Persistently intimidating | No longer in my life |
|   |   |  |   |  |

|  |  |  |  |
| --- | --- | --- | --- |
| 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 | Unreliably supportive | Apathetic to my need(s) | Persistently intimidating | No longer in my life |
|   |   |  |   |  |

|  |  |  |  |
| --- | --- | --- | --- |
| 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 | Unreliably supportive | Apathetic to my need(s) | Persistently intimidating | No longer in my life |
|   |   |  |   |  |

|  |  |  |  |
| --- | --- | --- | --- |
| 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 | Unreliably supportive | Apathetic to my need(s) | Persistently intimidating | No longer in my life |
|   |   |  |   |  |

|  |  |  |  |
| --- | --- | --- | --- |
| 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 | Unreliably supportive | Apathetic to my need(s) | Persistently intimidating | No longer in my life |
|   |   |  |   |  |

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** |  | **Family member** |
| Extreme depressed mood |  yes  suspect  no |  |
| Depression |  yes  suspect  no |  |
| Bipolar disorder |  yes  suspect  no |  |
| Anxiety disorder |  yes  suspect  no |  |
| Panic attacks |  yes  suspect  no |  |
| Schizophrenia |  yes  suspect  no |  |
| Alcohol/substance abuse |  yes  suspect  no |  |
| Eating disorders |  yes  suspect  no |  |
| Learning disabilities |  yes  suspect  no |  |
| Trauma history |  yes  suspect  no |  |
| Suicide attempts |  yes  suspect  no |  |
| Chronic illness |  yes  suspect  no |  |
|  |  yes  suspect  no |  |
|  |  yes  suspect  no |  |
|  |  yes  suspect  no |  |

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| --- | --- |
| 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?

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| --- | --- | --- | --- | --- | --- |
| Relative | critically supported | minimally supported | abandoned | main stressor | cut off contact |
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# INCOME-SOURCE INFORMATION

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| --- | --- |
| Are you currently employed? |  yes  no |
| If yes, who is your current employer/position? |  |

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| --- | --- | --- | --- | --- | --- |
| If yes, are you happy with your current position? | Very satisfied | Moderately satisfied | Neither satisfied nor dissatisfied | Moderately dissatisfied | Very dissatisfied |
|   |   |  |   |  |

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| --- | --- | --- | --- |
| Is your current job your primary source of income? |  yes  no | If no, does public assistance cover most of your living costs?  |  yes  no |
| 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 |
|   |   |  |   |  |
| 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 |
|   |   |  |   |  |
| 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 |
|   |   |  |   |  |

# RELIGIOUS/SPIRITUAL INFORMATION

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| --- | --- |
| 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 |

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| --- | --- | --- | --- | --- | --- |
| If you trust them to support you during life’s challenges, how would you rate their helpfulness? | overbearing | paternalistic | meaningful | disappointing | nonexistent |
|   |   |  |   |  |

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| --- | --- | --- | --- | --- | --- |
| 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 |
|   |   |  |   |  |

# OTHER INFORMATION

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| What is your highest level of education? | GED (or less) | high school diploma | some college/ vocational ed | college degree | post graduate degree |
|   |   |  |   |  |

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.

|  |
| --- |
|  |

# 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](https://en.wikipedia.org/wiki/Collateral_consequences_of_criminal_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: |
|  |  |

***Thank you for letting us serve you***.