CLIENT INTAKE FORM

CONFIDENTIAL

This intake form is to be completed by all new clients. The answers you provide will become part of your confidential records. Should you have any queries, or require assistance with any of the below questions, please feel free to ask your therapist.

Date: ___/___/___

First Name _____ Last Name _____

Date of Birth_____

Address _____

_____ Post Code _____

Home Tel. No. _____ Work Tel. No. _____ Ext. _____

Mobile No. _____ Email _____

Have you had any previous treatment for psychological issues? □ Yes □ No
If yes, please give details – i.e. when, where, how long, provider name, medications etc

Are you currently taking (or in the recent past, taken) any prescription or over-the-counter medications?
□ Yes □ No *If yes, please give details:*

Does anyone in your family (blood relatives) suffer with any psychological problems? □ Yes □ No
If yes, please give details:

Do you drink alcohol? □ Yes □No
If yes, please give details – how much, how often, any blackouts, etc.

Do you use any recreational drugs? □ Yes □No
If yes, please give details – what drugs, how often, last use etc.

Have you ever suffered from any type of eating disorder? □ Yes □ No.
If yes, please give details:

Do you have any work-related problems / difficulties in school? □Yes □ No.
If yes, please give details:

Do you have a history of trauma (any kind of abuse, neglect, victim of natural or other disaster etc)?
□ Yes □ No *If yes, please give details:*

Symptoms Checklist

Sleep: □ No problems □ Not enough □ Trouble getting up □ Nightmares □ Too much sleep

Appetite: □ No problems □ No interest □ Increased appetite □ Carbohydrate craving

Energy: □ Normal □ Increased □ Low □ Up and down

Interest in Sex: □ Normal □ Increased □ Low

Concentration: □ Normal □ Somewhat difficult □ Poor □ Terrible

Memory: □ Good □ Some difficulty remembering □ Poor

Depressed or sad: □ All the time □ Most days □ Some days □ Not at all

Suicidal thoughts: □ All the time □ Most days □ Some days □ Not at all

Past suicide attempts: □ No □ Yes
If yes, please give details:

Anxiety: □ All the time □ Most days □ Some days □ Not at all

Panic Attacks: □ Frequently □ Occasionally □ Not at all

Anger/Irritation: □ All the time □ Most days □ Some days □ Not at all

Any other Comments: