



**Initial Intake Form:** Please complete this form and bring it with you to your first appointment. If you believe a particular question does not pertain to you, please use N/A. The information provided in this form is intended only for the use of the individual or entity to which it is addressed. This information is private and protected from disclosure by law and held in strict confidence.

**Full Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Birth Date:** \_\_\_\_\_ **Current Occupation:** \_\_\_\_\_

**Home Address:** \_\_\_\_\_

**City/State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Primary Phone:** \_\_\_\_\_ **May I leave a message?**  \* Yes  No

**Text Message:** \_\_\_\_\_ **May I text you?**  \* Yes  No

**Email:** \_\_\_\_\_ **May I email you?**  \* Yes  No

*\* Please note: Email and text correspondence is not considered to be a confidential medium of communication*

**Emergency Contact:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**1. Presenting Problem**

\_\_\_\_\_  
\_\_\_\_\_

What is most important for you to accomplish during our initial meeting today?

\_\_\_\_\_  
\_\_\_\_\_

**2. History of Presenting Problem**

Events, precipitating factors, or incidents leading to need for services: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Frequency/duration/severity of symptoms: \_\_\_\_\_

\_\_\_\_\_

**3. Current Family and Significant Relationships**

Strengths/support: \_\_\_\_\_

Stressors/problems: \_\_\_\_\_

Recent changes: \_\_\_\_\_

Changes desired: \_\_\_\_\_



**4. Childhood/Adolescent/Adult History**

(Developmental milestones, past behavioral concerns, environment, abuse, social, mental health)

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**5. Social Relationships**

Strengths/support: \_\_\_\_\_

Stressors/problems: \_\_\_\_\_

Recent changes: \_\_\_\_\_

Changes desired: \_\_\_\_\_

**6. Cultural/Ethnic Information**

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**7. Spiritual/Religious Affiliation(s)**

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**8. Legal Involvement? (If yes, please explain)**

Status/impact/stressors: \_\_\_\_\_

**9. Medication or Herbal Supplements (If yes, please explain)**

Name/Dose: \_\_\_\_\_

Known Allergies: \_\_\_\_\_

**10. Military Service?** Yes  No  Current impact: \_\_\_\_\_

**11. Leisure/Recreational Activities**

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**12. Physical Health** (Are physical factors affecting mental condition?)

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**13. Substance Use History** (You, family member or friend)

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**14. Counseling/Prior Treatment**

Benefits of previous treatment: \_\_\_\_\_

Setbacks of previous treatment: \_\_\_\_\_



**AREAS OF CONCERN:**

**Please check any significant changes over the last year:**

- Work/School
- Job loss/Promotion
- Death(s)
- Illnesses
- Birth(s)
- Marital Status
- Relocation
- Other/Please Explain

**Please check any items that concern you at this time:**

- Work/School
- Depressive Symptoms
- Relationship Issues
- Spiritual Life
- Anxiety
- Sleeping
- Finances
- Self-Harm
- Job loss/Promotion
- Communication
- Focus
- Stress
- Legal Involvement
- Homicidal Thoughts
- Sex Life
- Suicidal Thoughts
- Death(s)
- Illness(s)
- Life Purpose
- Marital Status
- Social Life
- Eating
- Other/Please Explain

