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Client Intake Form

Date				ReferredBy:		
Last Name				First		Initial
Address		City		State, ZIP		
Home Phone	Contact? Y N	Business	Contact? Y N	Cell		Contact? Y N
Fax	Contact? Y N	E- Mail	Contact? Y N	CallingRestrictions		
Social Security Number		Date of Birth		Age		
Employer and Occupation						
Married Single Divorced Widow	Spouse		Child(s) Name/Age			
Physician(s) 1.		2.		3.		
Medical Problems						
Previous Psychotherapy Experience						

Insurance Company		Insurance Adjuster
Address		City, State, ZIP
Phone	Name of Insured	Insuredís Social Security Number
Employer	Group Number	Identification Number

*** Please read and answer questions on second page of form ***

3. The outcomes you are seeking from this treatment.

4. Your career history

   Are you currently satisfied with your career? ❍Y ❍N – If no, why are you dissatisfied?

5. Your relationship history

   Are you in a relationship now? ❍Y ❍N – If so, is the relationship fulfilling? ❍Y ❍N – If no, what do you feel is lacking?

6. Your support system (*i.e.*, friends, family, community, etc.)

   Do you feel adequately supported? ❍Y ❍N – If no, what do you feel is lacking?

7. What activities do you enjoy or find rejuvenating?

8. What people are or have been important resources for you?

9. We all have strengths and limitations. What are your strengths, capacities and inner qualities you feel you can rely on?

   How might you describe your limitations?

   What helps you get through difficult times?

10. Please feel free to add any other additional information you feel would be helpful for me to know (*i.e.*, testing of addiction, suicidal ideation or attempts, depression, anxiety, etc.).