



DEMOGRAPHICS INTAKE

Today's Date: _____ Client's Name: _____

Client's DOB: _____ Phone Number: _____

Home Address: _____

Referral Source: _____

Emergency Contacts Phone Number/Name:

_____	_____
_____	_____
_____	_____

Primary Guardian's First and Last Name (write n/a if not applicable):

Reason for Beginning Therapy: _____

Current Therapy goals: _____

How would you know that therapy was helpful for the client if you look back after the experience?

On a scale of 1-10 please rate the following related to Client.
(1 represents the lowest amount of disturbance and 10 represent the highest amount.)

Depression: 1 2 3 4 5 6 7 8 9 10

Anxiety: 1 2 3 4 5 6 7 8 9 10

Current Level of Suicidal ideation: 1 2 3 4 5 6 7 8 9 10

Rate your overall level of satisfaction in life: 1 2 3 4 5 6 7 8 9 10

Does the client have a psychiatrist? Yes No

Name: _____

Any history of medical or psychiatric hospitalizations? _____

If so, how many and where?

Any medicines for psychiatric purposes? Yes No

If so, please list:

MEDICAL HISTORY

Primary
Care Provider _____ Phone Number _____

Date of last visit? _____

Would you like us to inform your medical provider of the therapy your child receives here? Yes No

Is there a past or present history of substance abuse? Please explain:

Please list any history of family members with previous mental health diagnosis:

Please list any Prescription Medications: (Include Dosage and Duration):

Please describe the most concerning symptoms you have experienced in the last 3 months.

What would you say is the biggest reason in your opinion you have been struggling?
Please list any recent triggers.

How could either individual or group therapy be most helpful to you at this time?

Have you had previous positive or negative experiences with counseling?
If so please describe what was helpful or hurtful in your opinion:
