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General Client Intake Form

Please answer the following questions to the best of your abilities. These questions are to help the therapist with the therapy process. This information is held to the same standards of confidentiality as our therapy.

Name:_____
(Last) (Given) (Preferred) (Middle Initial)

Birth date: ____/____/____ Age:_____ Gender: Male ☐ Female ☐ Transgender

Marital status: Never married ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐

Number of children: _____
Ages:_____

Current address:
_____
(city) (state) (zip)

Home phone:_____ May we leave a message? Yes ☐ No ☐
Cell/other: _____ May we leave a message? Yes ☐ No ☐
Work phone: _____ May we leave a message? Yes ☐ No ☐
Email:_____ May we email you?* Yes ☐ No ☐
*NOTE: Emails may not be confidential

What is your preferred method of communication? SMS ☐ Email ☐ Phone ☐

Who may we contact in case of an emergency: _____ Telephone number_____

Are you currently receiving psychological services, professional counseling, psychiatric services, or any other mental health services? Yes ☐ No ☐

Reason for change:_____

Are you currently taking any psychiatric prescription medication? Yes ☐ No ☐
If yes, please list: _____

Have you been prescribed psychiatric prescription medication in the past? Yes ☐ No ☐
If yes, please list: _____

Have you been psychiatrically hospitalized in the past? Yes ☐ No ☐
If yes, please list dates and locations: _____

General Health Information

Please provide the name, address and telephone number for your primary care physician:
_____
_____
_____

How is your physical health at present? ☐ Poor ☐ Unsatisfactor ☐ Satisfactory ☐ Good ☐ Very good

Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, thyroid dysfunction, etc.):
_____
_____
_____

Are you on any medication for physical/medical issues? Yes ☐ No ☐
If yes, please list: _____

Are you having any problems with your sleep habits? Yes ☐ No ☐
If yes, circle those that apply:
Sleep too much ☐ Sleep too little ☐ Poor quality ☐ Disturbing dreams ☐
Other: _____

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Are there any changes or difficulties with your eating habits? Yes ☐ No ☐

If yes, circle those that apply:

Eating less ☐ Eating more ☐ Bingeing ☐ Restricting ☐

Other: _____

Have you experienced a weight change in the last two months? Yes ☐ No ☐

Do you exercise regularly? Yes ☐ No ☐

If yes, how many days per week do you exercise? _____ How many minutes/hours per session: _____

Do you consume alcohol regularly? Yes ☐ No ☐

In one month, how many times do you have four or more drinks in a 24-hour period? _____

How often do you engage in recreational drug use? Daily ☐ Weekly ☐ Monthly ☐

Rarely ☐ Never ☐

What kinds of recreational drugs do you use:

_____

Are you currently in a romantic relationship? Yes ☐ No ☐

If yes, how long have you been in this relationship? _____

On a scale from 1-10 (10 being great), how would you rate the quality of your relationship?

_____

In the last year, have you had any major life changes (e.g. new job, moving, illness, relationship change, etc.)?

_____

_____

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Quick Check

Check the issues below that apply to you.

Depressed mood ☐ Panic Attacks ☐ Memory Lapse ☐

Relationship Problems ☐

Mood Swings ☐ Phobias ☐ Trouble planning ☐

Hallucinations ☐

Rapid Speech ☐ Repetitive Behaviors ☐ Sleep Disturbance ☐ Eating ☐

difficulties ☐

Suicidal Thoughts ☐ Anxiety ☐ Time loss ☐ Body ☐

Complaints ☐

Homicidal thoughts ☐ Excessive Worry ☐ Alcohol/Drug abuse ☐

Traumatic Event ☐

Have you felt depressed recently? Yes ☐ No ☐

If yes, for how long? _____

Have you had any suicidal thoughts recently? Yes ☐ No ☐

If yes, how often? Frequently ☐ Sometimes ☐

Rarely ☐

Have you ever had suicidal thoughts in the past? Yes ☐ No ☐

If yes, how long ago? _____

How often did you have these thoughts? Frequently ☐ Sometimes ☐

Rarely ☐

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Family Mental Health History

The following is to provide information about your family history. Please mark each as yes or no. If yes, please indicate the family member affected.

Depression Yes ☐ No ☐
_____

Suicide Yes ☐ No ☐
_____

Anxiety Disorders Yes ☐ No ☐
_____

Bipolar Disorder Yes ☐ No ☐
_____

Panic Attacks Yes ☐ No ☐
_____

Alcohol/Substance Abuse Yes ☐ No ☐
_____

Eating Disorder Yes ☐ No ☐
_____

Trauma History Yes ☐ No ☐
_____

Domestic Violence Yes ☐ No ☐
_____

Sexual Abuse Yes ☐ No ☐
_____

Obesity Yes ☐ No ☐
_____

Obsessive Compulsive Behavior Yes ☐ No ☐
_____

Schizophrenia Yes ☐ No ☐
_____

Religious/Spiritual Information

Do you practice a religion? Yes ☐ No ☐

If yes, what is your faith?
_____

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Occupational Information

Are you currently employed? Yes ☐ No ☐

If yes, who is your employer? _____

What is your position? _____

Are you happy in your current position? Yes ☐ No ☐

Does your work make you stressed? Yes ☐ No ☐

If yes, what are your work-related stressors? _____

Other Information

List your strengths and what you like most about yourself: _____

List areas you feel you need to develop _____

What are some ways you cope with life obstacles and stress? _____

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What are your goals for therapy/what would you like to accomplish?

Preference for a session: Face-to-Face ☐ or Online Counseling ☐

By signing below, I acknowledge that I have chosen to receive mental health services in the form of evaluation and psychotherapy from KLM Counseling. My decision is voluntary, and I understand that I may terminate these services at any time. I also understand that during the course of treatment, I may need to discuss the material of an upsetting nature in order to resolve my problems. Further, I understand it cannot be guaranteed that I will feel better after the completion of treatment.

_____ _____

Signature Date

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