Client Name	

CLIENT INTAKE FORM

Please provide the following information for our records. Leave blank any question you would rather not answer. Information you provide is maintained within the strict confidentiality guidelines of this practice. Please complete the form and bring with you to your first session. Use back of form for additional information and comments.

CLIENT INFORMATION

Today's Date		Registration and Release Form Received and Signed		Yes / No
		Client Financial Agreement & Office Policies Signed		Yes / No
Name	(First)	(Middle)	(Last)	(Preferred)
Legal Guardian Name (if minor)				

NEEDS

1. What brings you to see me today? (Presenting issue / complaint)
2. Are you presently in therapy? YES / NO If yes with whom?
3. Previous therapy? With whom, what kind, how long?
4. How were you referred to me?

EMPLOYMENT

5. Employer		6. Occupation		7. Length	
8. Job Status	❍Full time ❍Part time ❍Student ❍Retired ❍Unemployed ❍Unemployed (looking for work) ❍Unemployed (disability/leave)				
9. Job Satisfaction / Feelings about being unemployed?					
10. Employment History					

EDUCATION

11. Highest grade completed?	❍ High School ❍GED ❍Vocational ❍Some College ❍Bachelors ❍Graduate Degree
12. Area of studies?	
13. Learning disabilities?	
14. Future educational goals?	

Client Name	

FAMILY / RELATIONHIPS

15. Current Relationship status?	❍Single (not involved) ❍Single (currently involved) ❍Dating ❍Married ❍Divorced ❍Separated ❍Widowed ❍Other (please explain)		
16. Partner / Spouse Name		17. How long together	
18. Living Situation?	❍Alone ❍With Spouse/Significant Other ❍Family ❍Friend / Roommate		
19. Satisfaction with living situation?			
20. Briefly describe your present relationship with your spouse or partner.			
21. Briefly describe relationships with any significant ex's.			

22. Number of children?		23. How many living with you?	
Name	Age	Relationship status and description. (include if you are biological, adopted or step parent)	Lives with you
			Yes / No
			Yes / No
			Yes / No
			Yes / No
			Yes / No

24. Family History — If deceased, how old were YOU when they died? Any known psychiatric illness? Relationship description.

	Name	Age	Alive	
Mother				
Father				
Sibling				
Sibling				
Sibling				
Sibling				
Sibling				

25. Raised by biological parents?	Yes / No	If no by whom?	
26.Were your parents divorced?	Yes / No If yes impact on you?		

Client Name	

27. Any other important/significant people in your life (past or present) eg. relatives, teachers, friends
28. Any significant deaths or losses?
29. Describe your major support system today. Who is your 2am emergency contact?

PHYSICAL HEALTH

30. Current Physical Health Status	❍Good ❍Problems	If problems please explain.
31. If problems has doctor completed a medical release if needed for body based work?		Yes / No / NA
32. Date of last medical exam and outcomes.		
33. Current physician's name		Phone
34. Alternative care provider		Phone

35. Medication(s) Name	Dose	Frequency	Reason	Prescribed by

RELATIONSHIP TO BODY

36. How do you feel about your body?	
37. Care for your body?	
38. Areas of body feel most tension?	
39. Parts of body you don't feel?	
40. Exercise?	
41. Diet / Nutrition	

42. Change in eating habits?	Yes / No	❍Eating less ❍Eating more ❍ Binging ❍Restricting
43. Have you experienced ❍significant weight gain ❍significant weight loss		How much
44. Trouble sleeping?	Yes / No	❍Sleep too little ❍Sleep too much ❍Poor quality ❍Disturbing dreams

Client Name	

DRUGS, ALCOHOL, & ADDICTIONS

45. Do you use alcohol regularly?	Yes / No	If yes please describe?	
46. How often do you engage in recreational drug use?	❍Daily ❍Weekly ❍Monthly ❍Rarely ❍Never		
47. Do you, friends, or family feel you have a problem with alcohol or drugs?	Yes / No	If yes please explain.	
48. Have you ever been hospitalized for drugs or alcohol?	Yes / No	If yes please explain.	
49. Any other additiction issues?	Yes / No	If yes please explain.	
50. Do you attend any 12 step meetings?	Yes / No	If yes please explain.	

MENTAL HEALTH

51. Any current mental health problems, for example with depression or anxiety?			Yes / No	If yes please explain.	
52. Are present thoughts about wanting to harm yourself? (ie. Cutting, etc.)			Yes / No	If yes please explain	
53. Any history around thinking about suicide or attempting to take your life?			Yes / No	If yes please explain	
Age at previous attempts		Were you hospitalized?	Yes / No	Medications	
54. Have you ever planned or attempted to hurt or harm another person?			Yes / No	If yes please explain	
55. What feelings do you have the most challenges or trouble with? (Joy, Sadness, Anger, Shame, Guilt)					

TRAUMA HISTORY

56. Please list your major traumas. Age, what happened, how it impacts you today, how did you process?

Client Name	

MILITARY / LEGAL

57. Have you served in the military?	Yes / No	Veteran of War?	Yes / No	Enlisted Dates	
How did this impact your life?					

58. Have you ever been arrested for a crime?	Yes / No	If yes, date of arrest
Nature of arrest		Status

LEISURE / SPIRITUALITY

59. What kinds of hobbies and interests do you have?		
60. Are you a member of any religious organization or spiritual practice?	Yes / No	If yes please explain
61. How important is spirituality in your life?		

PSYCHOSEXUAL

62. What is your sexual identity?			
63. Number of sexual partners ?	One	Multiple	If multiple how many & does primary partner know?
64. Is your sex life satisfactory? How often do you engage in sex?			
65. Do you engage in self pleasure?			
66. Do you practice safe sex?			
67. How do you feel about yourself as a man/ woman?			

68. Have you ever been sexually abused or raped?	Yes / No	If yes please explain
69. Do you have any issues around sexuality that you want to address?		

CORE ENERGETICS & GOALS

70. Core Energetics works with the mind, body and spirit. How is that important to you and why?
71. Name three characteristics of yourself that you like.
72. Name three characteristics about yourself that you want to change or transform.
73. What do you hope to get out of this process?