CLIENT INTAKE FORM

Date of first appointment: ____________

Please take your time in providing the following information. The questions are designed to help me begin to understand you so that our time together can be as productive as possible. All information provided is confidential.

Referred by: ___________________________________

Have you previously received any type of mental health services?

Yes ( ) No ( )

If yes, which of the following:

Psychotherapy / Medication / Outpatient Hospitalizations / Inpatient Hospitalization

If yes, please provide:

Name of provider or facility:____

Location:_______________________________________Dates of treatment:____________________

Reason for treatment:____

Briefly, what brings you in today?

When did your problem first start?

130 GREENFIELD AVE, SUITE A • SAN ANSELMO, CA. 94960415.847.7471
ALICESHELA@GMAIL.COM • WWW.ALICETREVESLCSW.COM • LICENSE# 22144

What areas of your life have been affected because of this problem?

Are you currently experiencing overwhelming sadness, grief or depression? Yes ( ) No ( )

If yes, for approximately how long? ________________________

Are you currently experiencing anxiety, panic attacks or have any phobias? Yes ( ) No ( )

If yes, when did you begin experiencing this? ________________________

Please describe any major losses or traumas you have experienced at any point in your life:

What significant life changes or stressful events have you experienced recently?

What would you like to accomplish out of your time in therapy?

130 GREENFIELD AVE, SUITE A • SAN ANSELMO, CA. 94960415.847.7471
ALICESHELA@GMAIL.COM • WWW.ALICETREVESLCSW.COM • LICENSE# 22144

Family History:

Where were you born? ____

Where did you grow up? ______________________________________

Please list your parents, siblings and children.

First Name or initials	Age	Relationship	Where they live	If deceased, age and cause of death

Who did you live with while growing up? ____

Mother's occupation: ____

Father's occupation? ____

Three Adjectives to describe your **relationship** growing up with each parent (or primary caregiver):____

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

Condition	**Please Circle**	**List Family Member**
Alcohol/Substance Abuse	Yes/No	
Anxiety	Yes/No	
Depression	Yes/No	
Domestic Violence	Yes/No	
Sexual Abuse	Yes/No	
Eating Disorders	Yes/No	
Obesity	Yes/No	
Obsessive Compulsive disorder	Yes/No	
Bipolar/Manic Depression	Yes/No	
Psychosis	Yes/No	
Personality Disorders	Yes/No	
Suicide Attempts	Yes/No	
Other diagnosed condition	Yes/No	

Are you currently in a romantic relationship? Yes ( ) No ( )

If Yes, How long? _______

On a scale of 1-10 (best), how would you rate your relationship? ________________________

130 GREENFIELD AVE, SUITE A • SAN ANSELMO, CA. 94960415.847.7471
ALICESHELA@GMAIL.COM • WWW.ALICETREVESLCSW.COM • LICENSE# 22144

Physical Health:

Please list any medications, herbs, or supplements. Be sure to include the condition, as some medications are prescribed for off-label use. Continue on the back if needed, or provide a separate list.

Medication/Supplement	Dosage	Condition	Date Began/ Stopped

Prescribing provider and contact information:

Name: ____

Specialty: ____

Phone or email____

How would you rate your current physical health?

Poor ( ) Unsatisfactory ( ) Satisfactory ( ) Good ( ) Very Good ( )

Please list any specific health problems you are currently experiencing:

How would you rate your current sleeping habits?

Poor ( ) Unsatisfactory ( ) Satisfactory ( ) Good ( ) Very Good ( )

If you are having problems, in which phase of sleep are you experiencing issues?

Falling asleep ( ) Staying asleep ( ) Awakening early ( ) Sleep apnea ( )

Please list any other specific sleep problems you are currently experiencing:

How many times per week do you generally exercise? ____________

What types of exercise do you participate in:

Are you currently experiencing any chronic pain? No ( ) Yes ( )

Please describe current use of alcohol, cigarettes, and/or recreational drugs:

Additional Information:

What do you enjoy about your work (full-time homemaker included)?

If retired, what did you enjoy about your work?

What do you find particularly stressful about your current or previous work?

What do you enjoy doing in your free time?

What do you do to relax?

Do you consider yourself to be spiritual or religious?

If yes, please describe your faith or belief:

What do you consider to be some of your strengths?

What do you consider to be some of your weaknesses?

130 GREENFIELD AVE, SUITE A • SAN ANSELMO, CA. 94960415.847.7471
ALICESHELA@GMAIL.COM • WWW.ALICETREVESLCSW.COM • LICENSE# 22144