

to bear witness

THERAPY

Client History and Intake Information

Date: _____ Client Name: _____

Date of Birth: _____ SS # (last 4 digits): _____

I identify my gender as _____ Pronouns _____

I identify my race/ethnicity as _____

Home Address:

Cell Phone Number: _____ May I leave a voicemail? [] Yes [] No

May I text message you? [] Yes [] No

Email: _____ May I email you? [] Yes [] No

Emergency Contact Name: _____

Relationship: _____ Phone Number: _____

Please describe your current concerns.

What are your goals and hopes for therapy?

Please mark any symptoms you are experiencing.

<i>Personal Symptoms</i>		
difficulty concentrating	thoughts of self-harm	impatient
confusion	thoughts of harming others	irritable/moody
loss of meaning or purpose	prenatal/perinatal concerns	withdrawn
decreased self esteem	guilt	hearing things others do not
intrusive thoughts	numbness	sleep disturbances
hopelessness	fear	emotional roller coaster
flashbacks	depression	body image concerns
questioning spirituality	anxiety	food-related struggles
sexual concerns	isolation	nightmares
impaired immune system	loneliness	hypervigilance
body aches and pain	racing thoughts	substance abuse
Others:		
<i>Occupational/Professional Issues</i>		
low motivation	poor communication	impaired judgment
increase in mistakes	conflicts at work	irritability/anger
decrease in confidence	missing work more often	showing up late
loss of passion	exhaustion	long work hours
struggle with balance	demoralized/unappreciated	detachment
harmful work environment	trauma exposure	boundary issues
Others:		

*Symptoms adapted from Yassen's Tables of Personal and Professional Impact of Secondary Traumatic Stress

Have you had mental health treatment in the past (therapy, medication management, hospitalization, IOP, etc) [] Yes [] No If yes, please briefly describe:

What did you like/dislike about past treatment? _____

Have you had any past suicide attempts? [] Yes [] No

Please list dates to the best of your knowledge: _____

Have you experienced events you feel are traumatic (in the past or present)? [] Yes [] No If yes, please briefly describe (if you feel safe doing so):

What kind of impact (if any) has the pandemic and/or world events had on your mental health?

What has helped you survive hard times you have experienced? _____

List any current medications:

List any physical health concerns, serious illnesses, conditions, or major medical experiences:

Allergies: _____

Have you had COVID? [] Yes [] No If yes, did it cause any lasting effects on your mental or physical health?

Have you ever had a head injury? [] Yes [] No If yes, did it cause any lasting effects on your mental or physical health?

Who do you consider your support system (family, coworkers, partner, friends, pets, etc)?

Any family history of substance abuse, mental illness, trauma, or suicide?

Do you have any relationship concerns? [] Yes [] No If yes, please describe: _____

What is your current employment status? [] Employed Full-Time [] Employed Part-time
[] Unemployed [] Disability [] Student [] Volunteer

Occupation: _____

Please list likes/dislikes about your occupation, and vocation goals (if any):

Do you use any substances or drink alcohol (social, habitual, spiritual use etc)? [] Yes [] No

Have you ever had concerns about your substance use or any addictive behaviors?

Yes No

Have other people ever had concerns about your substance use or any addictive behaviors?

Yes No

If you answered yes to any, please describe: _____

Have you ever had any legal issues or involvement with the criminal justice system?

Yes No If yes, please describe:

Is there anything that gives your life a sense of purpose and meaning? Please describe.

What do you do for fun/self-care?

Is there anything else you would like me to know about you?
