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.

	Personal Symptoms				
	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	loss of meaning or purpose		prenatal/perinatal concerns		withdrawn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:				
	Occupational/Professional Issues				
	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**

Mental Health

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

Are you currently on any prescribed medications for your mental health? [ ] Yes [ ] No

If yes, please list _____

Have you experienced events you feel are traumatic (in the past or present)? Please describe to the extent you feel comfortable with.

_____

_____

_____

_____

What has helped you survive the hard times you have been through? _____

_____

_____

Physical Health

List any current medications:

_____

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

_____

_____

_____

Allergies: _____

Family and Relationships

Who do you consider your family or support system (parents, children, friends, pets, etc)?

_____

_____

_____

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

_____

_____

Do you have any relationship concerns? [ ] Yes [ ] No _____

_____

_____

Employment History

What is your current employment status? [ ] Employed Full-Time [ ] Employed Part-time

[ ] Unemployed [ ] Disability [ ] Student [ ] Volunteer

Occupation: _____**List likes/dislikes about your occupation:**

_____

_____

Substance Use

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:_____

_____

_____

_____

Legal History

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

[ ] Yes [ ] No If yes, please describe:

_____

Strengths

What are your personal strengths?_____

_____

_____

Please describe any spiritual or religious beliefs you hold (if any)

_____

_____

What do you do for fun/self-care?

_____

_____

_____

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

_____

_____

_____