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CLIENT REGISTRATION AND INTAKE FORM

Personal Information

Name: _____ Date: _____
Address: _____
Phone numbers: Mobile: _____ Home: _____ Work: _____
Email address: _____
Date of Birth: _____ Age: _____ Sex: _____ Marital Status: _____
Primary Physician: _____ Phone: _____
Emergency Contact: _____ Relationship: _____ Phone: _____

Complaint

What is your major complaint? _____
Start Date: _____ Have you previously suffered from this complaint? _____
Previous therapist(s) seen for complaint: _____
Previous treatment for complaint: _____
Aggravating Factors: _____ Relieving Factors: _____

Current Symptoms (Check All That Apply)

☐ Anxiety/Worry	☐ Changes in Appetite	☐ Computer Addiction	☐ Crying Spells
☐ Distractibility	☐ Excessive Energy	☐ Racing Thoughts	☐ Compulsive Behavior
☐ Guilt/Shame	☐ Impulsivity	☐ Work/School Problems	☐ Sexual Problems
☐ Hyperactivity	☐ Panic Attacks	☐ Gambling Problems	☐ Risky Activity
☐ Sleep Problems	☐ Suspicion/Paranoia	☐ Depression/Sadness	☐ Aggression/Fights
☐ Loneliness	☐ Low Self-Worth	☐ Loss of Interest/Pleasure	☐ Self-Harm Behavior
☐ Avoidance	☐ Lack of Motivation	☐ Homicidal Thoughts	☐ Parenting Problems
☐ Eating Problems	☐ Fatigue/Low Energy	☐ Withdrawal from People	☐ Drug/Alcohol Use
☐ Flashbacks	☐ Irritability	☐ Relationship Problems	☐ Thoughts of Death
☐ Mood Swings	☐ Social Discomfort	☐ Hearing Voices	☐ Obsessive Thoughts
☐ Feeling Hopeless	☐ Weight Changes	☐ Physical Pain	☐ Problems with Anger
☐ Nightmares	☐ Feeling Stressed	☐ Perfectionism	☐ Feeling Fearful
☐ Visual Hallucinations	☐ Memory Problems/ Confusion	☐ Recurring/Disturbing Memories	☐ Problems with Pornography

Family History

Were you adopted? _____ If yes, at what age? _____ Lived in a foster home? _____
How is your relationship with your mother? _____
How is your relationship with your father? _____
Siblings and their ages: _____
Are your parents married? _____
Did your parents divorce? _____ If yes, how old were you? _____
Did your parents remarry? _____ If yes, how old were you? _____
Who raised you? _____ Where did you grown up? _____
Parental substance abuse: _____
Family member medical conditions: _____
Family member mental conditions: _____

Treated with medication? _____
Medications: _____

Early Development

Where did you grow up? _____
How often did you move and where? _____
How old were you when you left home? _____
Have any immediate family members died? _____ Who? _____
Have any committed suicide? _____ Who? _____
Describe any neglect you suffered, and by whom: _____
Trauma suffered and by whom: _____
Abuse suffered and by whom: _____
Highest education level completed: _____
Date completed and location: _____
Have you ever served in the military? _____ If yes, where? _____
Dates of service: _____ Highest rank achieved: _____

Medical History

Exercise Frequency: _____ Exercise Type(s): _____
Date of last physical exam: _____
Allergies: _____
What medications are you currently taking? _____
Current medical condition: _____
Previous medical conditions: _____
Previous mental health treatment: _____
Major injuries or accidents: _____
Major illnesses: _____
Previous surgeries: _____

Have You Ever Tried the Following (Check All That Apply)

☐ Alcohol	☐ Tobacco	☐ Marijuana	☐ Hallucinogens (LSD)
☐ Caffeine	☐ Methamphetamines	☐ Cocaine/Crack	☐ Stimulants (Pills)
☐ Ecstasy	☐ Methadone	☐ Tranquilizers	☐ Pain Killers
☐ Heroin	☐ Inhalants	☐ Steroids	☐ Other

If yes to any, list frequency/dates of use: _____

Have you ever been treated for drug/alcohol abuse? _____ If yes, when? _____
For which substances? _____
Do you smoke cigarettes? _____ If yes, how many per day? _____
Do you drink caffeinated beverages? _____ If yes, how many per day? _____
Have you ever abused prescription drugs? _____ If yes, which ones? _____

Present Situation

Work: ☐ Full-Time ☐ Part-Time ☐ Student ☐ Unemployed ☐ Disabled ☐ Retired
Length of time in current situation: _____
Are you married? _____ If yes, date of marriage: _____
Are you divorced? _____ If yes, date of divorce: _____
Prior marriages? _____ If yes, how many? _____
What is your sexual orientation? _____ Are you sexually active? _____
How is your relationship with your partner? _____
Do you have children? _____ Dates of Birth: _____
How is your relationship with your child(ren)? _____
List anyone else who lives with you: _____
Are you a member of a religion/spiritual group? _____
What is your level of involvement? _____
Have you ever been arrested? When and why?