Indy Therapy and Counseling - ADULT Client Intake Form

The purpose of this intake form is to save a great deal of valuable therapy interview time. Therefore by answering these routine questions as fully and accurately as you can, it will make it possible for us to get to work on the issues that concern you the most more quickly. All responses are strictly confidential and will not be released without your written permission. If you have any questions about this questionnaire, please feel free to call.

CLIENT Name _____Date of Birth:_____

Address_____

City_____State_____Zip _____

Primary Phone (_____)_____ (home / mobile / work / other)

Secondary Phone (_____)_____ (home / mobile / work / other)

Employer _____

Email:_____

Emergency Contact _____

Name Relationship Contact #

If seeking couples counseling please fill out Partner information

CLIENT Name _____Date of Birth:_____

Address_____

City_____State_____Zip _____

Primary Phone (_____)_____ (home / mobile / work / other)

Secondary Phone (_____)_____ (home / mobile / work / other)

Employer _____

Email:_____

Emergency Contact _____

Name Relationship Phone #

Is primary client responsible for billing? YES / NO

If not, please fill out Billable Party information.

BILLABLE PARTY Name _____

Address_____ City_____ State____ Zip _____

Primary Phone (_____)_____

Communication of Private Mental Health Information
There may be times when Indy Therapy and Counseling staff needs to contact you in regards to appointment times, account questions, or other reasons relating to your care.
May we contact you by listed email? **YES / NO** May we leave a voicemail? **YES / NO**

How did you hear about us?

_____

Marital Status:
__ Single __ Dating __ Engaged __ Married __ Separated __ Divorced __ Widowed

Partner's Name: _____Age:_____

Living together? **YES / NO** Years together: _____

Previously Married: **YES / NO** (if yes, how many times? _____)

Partner Previously Married: **YES / NO** (if yes, how many times? _____)

Children's Names: (Include and identify step-children)

_____ Sex: ___ Age: ___ Grade: ___ Married: ___

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_____ Sex: ___ Age: ___ Grade: ___ Married: ___

Health
Do you have any physical symptoms that concern you?

_____

_____

Primary Physician:_____ Phone #:_____

Are you currently taking any prescription medication? **YES / NO**

If yes, please list (use back of paper if necessary): _____

_____

Reason for Seeking Therapy

My reason(s) for seeking therapy is/are:

_____

_____

_____

_____

_____

What solutions to your problem(s) have you found helpful?

_____

_____

_____

_____

When did the problem(s) begin? (Date)

_____

Other personal concerns I have include:

__ Anxious	__ Trauma History	__ Feeling Angry
__ Feeling Depressed	__ Nightmares/Flashbacks	__ Sleep troubles
__ Shame	__ Unsafe behaviors	__ Grief
__ Low self-esteem	__ Family tension/conflict	__ Parenting concern
__ Self Harm	__ Suicidal Thoughts	__ Hopelessness
__ Financial stress	__ Sexual difficulties	__ Religious concerns
__ Addiction concerns	__ Frequently feeling unsafe	__ Work stress
__ Infidelity Concerns	__ Eating problems	__ Lack of trust
__ Difficulty controlling worry	__ Difficulty controlling fear	__ Difficulty socializing
__ Marital Issues	__ Communication Issues	__ Custody Problems

__Other: _____

Individual and Family Questionnaire

Check any of the following that applied in your family during your youth:

__ Divorce	__ Separation	__ Legal Troubles
__ Affairs	__ Alcohol Abuse	__ Drug Abuse
__ Verbal Abuse	__ Sexual Abuse	__ Physical Abuse
__ School Problems	__ Death	__ Medical Illness
__ Eating Disorder	__ Emotional Problems	__ Suicide

__ Other Impactful Family History (Please describe)

_____

_____

Family members with mental illness:

Relationship:_____ Specific Illness: _____

Relationship:_____ Specific Illness: _____

Relationship:_____ Specific Illness: _____

Religious / Spiritual

I consider myself a religious/spiritual person? **YES / NO / UNCERTAIN**

My religious preference is (if applicable): _____

How important is spirituality in your life? (Low) 1 2 3 4 5 6 7 8 9 10 (High)

Employment

Rate your job satisfaction: (Low) 1 2 3 4 5 6 7 8 9 10 (High)

What do you enjoy most about your job?_____

What do you dislike most about your job? _____

Social

List and rate the three people you have the closest relationship

Name:_____ Years Known: _____
(Acquaintance) 1 2 3 4 5 6 7 8 9 10 (Deep Relationship)

Name:_____ Years Known: _____
(Acquaintance) 1 2 3 4 5 6 7 8 9 10 (Deep Relationship)

Name:_____ Years Known: _____
(Acquaintance) 1 2 3 4 5 6 7 8 9 10 (Deep Relationship)

Previous Therapy

Have you had previous experience with counseling? **YES / NO**

If yes, when: _____ Therapist:_____

When: _____ Therapist: _____

For you, therapy will be successful when:

_____

_____

_____

The likelihood that therapy will succeed is:

VERY GOOD / GOOD / POOR / VERY POOR

I expect it will take _____ sessions to complete my therapy goals.

Did we miss something?

Write anything else you would like your clinician to know before first appointment.

_____

_____

_____

_____

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