INDIVIDUAL INTAKE FORM

Please provide the following information. It will be handled in the same manner as our therapy in regard to confidentiality.

Full Legal Name: _____ Date: _____
Preferred Name: _____
Date of Birth: _____ Age: _____ Gender: _____ Pronouns: _____
Address: _____
_____

Cell Phone: _____ May I leave a voice message? □ Yes □ No
May I leave a text message? □ Yes □ No
Home Phone: _____ May I leave a message? □ Yes □ No
Email Address: _____ May I email you? □ Yes □ No

How did you hear about Authentic Living? _____
_____

Relationship Status: □ Never Married □ Partnership □ Married □ Separated □ Divorced □ Widowed

HOUSEHOLD INFORMATION

List those in your current household:

Name	Relationship to You	Gender	Age

Please list any other immediate family members/significant others that do not live with you: _____
_____
Do you have any concerns about your current living situation or environment? _____
_____

OCCUPATIONAL INFORMATION

Are you currently employed? □ Yes □ No
If yes, what is your position/place of employment? _____
If yes, are you satisfied in your current position? _____
List any work-related stressors, if any: _____

HEALTH AND COUNSELING HISTORY

Please list any other health care professionals you are currently working with: _____

_____

Please list any medications you are currently taking: _____

_____

Please list any other medications you have taken in the past on a long-term basis:_____

_____

Have you seen a therapist or mental health professional in the past? □ Yes □ No If yes, please describe:

_____

_____

When was your last physical? _____

How is your current physical health? □ Poor □ Unsatisfactory □ Satisfactory □ Good □ Very good

Please list any persistent physical symptoms or health concerns (headaches, chronic pain, etc): _____

_____

Are you having trouble sleeping? _____ □ Yes □ No If yes, please describe:

_____

_____

How often do you engage in physical activity and what do you do? _____

_____

Please list any difficulties you experience with your appetite or eating patterns: _____

_____

Have you experienced significant weight changes in the last 2 months? □ Yes □ No

Do you regularly use alcohol? □ Yes □ No

In a typical month, how often do you have 4 or more drinks in a 24-hour period? _____

How often do you engage in recreational drug use? □ Daily □ Weekly □ Monthly □ Rarely □ Never

Has anyone told you they were concerned about your alcohol/drug use? □ Yes □ No

Have you had suicidal thoughts recently? □ Frequently □ Sometimes □ Rarely □ No

Have you had suicidal thoughts in the past? □ Yes □ No If yes, have you attempted? □ Yes □ No

What significant life changes or stressful events have you experienced in the last year? _____

_____

_____

Have you ever experienced?

□ Yes	□ No	Extreme Depressed Mood	□ Yes	□ No	Alcohol/Substance Abuse
□ Yes	□ No	Wild Mood Swings	□ Yes	□ No	Frequent Body Complaints
□ Yes	□ No	Rapid Speech	□ Yes	□ No	Eating Disorder
□ Yes	□ No	Extreme Attacks	□ Yes	□ No	Body Image Problems
□ Yes	□ No	Phobias	□ Yes	□ No	Repetitive Thoughts (i.e. obsessions)
□ Yes	□ No	Sleep Disturbances	□ Yes	□ No	Repetitive Behaviors (i.e. frequent hand washing, checking, etc.)
□ Yes	□ No	Hallucinations			
□ Yes	□ No	Unexplained Losses of Time/Memory Lapses	□ Yes	□ No	Homicidal Thoughts
			□ Yes	□ No	Suicide Attempt
□ Yes	□ No	Chronic, Unexplained Pain			

FAMILY MENTAL HEALTH HISTORY

Please 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.).

□ Yes □ No Alcohol/Substance _____
□ Yes □ No Mental Health Issues _____
□ Yes □ No Suicide Attempts _____
□ Yes □ No Chronic or Significant Physical Illness _____
□ Yes □ No Physical/sexual/emotional or verbal abuse _____
□ Yes □ No Learning Disabilities _____
□ Yes □ No Trauma History _____

PERSONAL STRENGTHS AND BACKGROUND

What do you consider to be some of your strengths? _____
_____

What are you most proud of? _____
_____

What are a few personal challenges you manage? _____
_____

How important is spirituality in your life? Low ---------- High

What are your spiritual or religious beliefs? _____
_____

How do you describe your racial, ethnic, or cultural background?_____
_____

How would you describe your sexual/romantic orientation?_____

What are effective coping strategies that you've learned? _____
_____
_____

Please list important parts/people that make up your support system: _____
_____

Is there anything else you'd like me to know? (Use the back for more space) _____
_____

TREATMENT PLAN

Please complete the form as best you can. If you are unsure of your answers this can also be completed in session.

What brings you to therapy and why now?

_____
_____
_____
_____

What are your goals for therapy?

_____
_____
_____
_____

How will you know that you're making progress?

_____
_____
_____
_____

_____ _____

Client Signature **Date**

_____ _____

Therapist Signature **Date**