

# CLIENT INTAKE FORM

Please complete the following intake questions. In accordance with the ethical guidelines of my counseling license, the information provided is protected under the confidentiality laws set forth by the state of Pennsylvania.

Please complete this form and bring it to your first session.

Name: \_\_\_\_\_ Address \_\_\_\_\_

Email: \_\_\_\_\_

Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_

Gender Identification: \_\_\_\_\_ Pronouns: \_\_\_\_\_

Relationship Status: Single Married (years?) Divorced Partnered Domestic Partner  
Widowed

Please list any children/ages: \_\_\_\_\_

Phone: home \_\_\_\_\_ Cell \_\_\_\_\_ Work \_\_\_\_\_

Education (high school, college, highest degree) \_\_\_\_\_

Military Background \_\_\_\_\_

Referred by (if any) \_\_\_\_\_

In case of emergency: Name \_\_\_\_\_ Phone \_\_\_\_\_

Please list the name, year and length of any type of counseling (individual, couple's, family, inpatient, partial hospitalization, drug, alcohol, gambling, sex addiction counseling or inpatient rehab.) you have received prior to this session. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Briefly describe your reason for seeking therapy at this time. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## General Health and Mental Health Information

1. How would you rate your current physical health?) *(please circle)*

Poor Unsatisfactory Satisfactory Good Very Good

2. Please identify any sleep difficulties. *(please circle)*

Falling asleep Waking up Nightmares Insomnia

3. How many times per week do you exercise? \_\_\_\_\_ Type of exercise?

\_\_\_\_\_

4. Identify any changes in your eating patterns, weight gain or loss, in the last 3 months. \_\_\_\_\_

5. Please identify any significant changes in the following emotional states:

Grief Anger Anxiety Panic Attacks Sadness Hopelessness

6. Are you currently experiencing any chronic pain? \_\_\_\_\_

7. Please identify specific life stressors that have occurred over the last year, i.e.,

job change or loss, relationship break up , death, trauma. \_\_\_\_\_

\_\_\_\_\_

8. Please describe your alcohol and/or drug usage in any given week.

\_\_\_\_\_

9. Please describe your computer usage (aside from work related) ,i.e., pornography, games, social networking, general surfing, emailing. \_\_\_\_\_

\_\_\_\_\_

10. Please list any types of non-traditional healing methods, current or past, i.e., acupuncture, yoga, meditation, chiropractic, herbs, reiki, massage. \_\_\_\_\_

\_\_\_\_\_

11. Current and past psychiatric medications? \_\_\_\_\_

## Family of Origin Relationships

(in six words or less)

1. Describe your relationship with mother growing up (e.g., loving, chaotic, cold, secure, insecure, never around, she was depressed, critical, hard working, self absorbed, caring, etc).
2. Describe your relationship with father growing up.....
3. How many siblings? \_\_\_ What was your birth order? \_\_\_. Give a summary of these relationships (competitive, supportive, fighting, close, distant, etc.)
4. Describe your relationships with grandparents (close, loving, supportive, distant)
5. When I felt scared, sad, alone, sick.....the person I would go to was my\_\_\_\_\_.
6. As a child I most often felt (circle two)....  
alone curious loved angry happy scared safe
7. A childhood incident that strongly influenced your life(positive and/or negative).

## Additional Information

Current Employment (where, length, full/part time, job satisfaction)\_\_\_\_\_

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Spiritual Connection (church, temple, meditation, prayer, yoga, etc.)\_\_\_\_\_

What might you notice or expect will be different about you after we complete our work together?\_\_\_\_\_

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• *I consent to receive treatment for therapeutic services.*

• *I understand that you are not participating with my insurance company and that payment is due at time of service and failure to cancel your appointment within a 24 hour window will result in full charge for the reserved time slot.*

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• *Good Faith Estimate- The fee for a 55 minute psychotherapy visit ( in-person or via telehealth) is \$120. Most clients will attend one psychotherapy visit per every (other) week, but the frequency of psychotherapy visits vary, depending on your progress. Based upon a fee of \$120. per visit, if you attend one psychotherapy visit every other week, your estimated charge would be \$\_240.\_for two visits provided over the course of one month; \$\_480 four visits over two months; or \$820.-for six visits over three months. If you attend therapy for a longer period, your total estimated charges will increase according to the number of visits and length of treatment.*

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• *I understand that you do not have 24 hour on call services. Therefore in the case of an emergency I will call 911 or the number of my local Crisis Intervention if this need were to arise, where seconds count.*

• *I understand that my therapist and the treatment I receive are bound by HIPPA/Privacy Practices.*

• *Client Signature* \_\_\_\_\_ *Date* \_\_\_\_\_

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