CULTIVATING CHANGE
SPRINGFORTH COUNSELING

Client Intake Form

Please fill out this form and bring it to your first session. Please note: information you provide here is protected as confidential information.

Name: _____
(First) (Last) (Middle Initial)

Birth Date: ____/____/____ Age: _____ Gender: ☐ Male ☐ Female

Marital Status: ☐ Never Married ☐ Domestic Partnership ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Address:

_____
(Street and Number) (City) (State) (Zip)

Home Phone: _____May I leave a message? ☐ Yes ☐ No
Cell/Other Phone: _____May I leave a message? ☐ Yes ☐ No

E-mail: _____ May I email you? ☐ Yes ☐ No

*Please note: Email correspondence is not considered to be a confidential medium of communication.

Emergency Contact Information: Name _____
Relationship _____ Phone: _____

Doctor's Name: _____Phone: _____
Would you like me to contact your doctor to coordinate your treatment? ☐ Yes ☐ No

Referred by (if any): _____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)? ☐ No ☐ Yes, previous therapist/practitioner: _____

_____

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Are you currently taking any prescription medication? □ No □ Yes Please list:

Have you ever been prescribed psychiatric medication?

□ No □ Yes Please list and provide dates: _____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

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

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:

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2. How would you rate your current sleeping habits? (Please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:

---

3. How many times per week do you generally exercise? _____

What types of exercise do you participate in: _____

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

---

5. Are you currently experiencing overwhelming sadness, grief or depression? □ No
□ Yes For how long? _____

6. Are you currently experiencing anxiety, panic attacks or have any phobias? □ No
□ Yes When did you begin experiencing this? _____

7. Are you currently experiencing any chronic pain? □ No □ Yes
If yes, please describe:

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8. Do you drink alcohol more than once a week? □ No □ Yes

9. How often do you engage in recreational drug use? □ Daily □ Weekly □ Monthly □ Infrequently □ Never

10. Are you currently in a romantic relationship? □ No □ Yes For how long: _____
On a scale of 1 – 10, how would you rate your relationship? _____
11. What significant life changes or stressful events have you experienced recently?

_____
_____
_____

FAMILY MENTAL HEALTH HISTORY:

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you (father, grandmother, uncle, etc.).

Member	Please circle	List Family
Alcohol/Substance Abuse Anxiety	yes/no	
Depression	yes/no	
Domestic Violence	yes/no	
Eating Disorders	yes/no	
Obesity	yes/no	
Obsessive Compulsive Behavior Schizophrenia	yes/no	
Suicide Attempts	yes/no	

ADDITIONAL INFORMATION:

1. Are you currently employed? □ No □ Yes

If yes, what is your current employment situation?_____
_____
Do you enjoy your work? Is there anything stressful about your current work?

_____

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2. Do you consider yourself to be spiritual or religious? □ No □ Yes
If yes, describe your faith or belief:

_____

3. What do you consider to be some of your strengths?

_____

_____

4. What do you consider to be some of your weaknesses?

_____

_____

5. What would you like to accomplish out of your time in therapy?

_____

_____

_____

6. Why have you decided to come at this time? _____

_____

7. Describe any particular concerns, fears or questions you have regarding therapy:

_____

_____

Information relating to counseling

Information related to counseling Who may I thank for your referral? _____
Have you ever consulted a counselor before? Yes No
With whom? _____
Are you currently in counseling elsewhere? Yes No With whom? _____
Outcome and/or Diagnosis: _____

Printed Name _____ Date: _____
Client Signature_____ Date: _____