Negeen Moussavian
THERAPY

CLIENT INTAKE FORM
CONFIDENTIAL INFORMATION

Today's Date: _____

Name: _____Birth Date: _____

Home Address: _____ City: _____

Home Phone: _____ Cell Phone: _____

Circle the number you prefer me to call you at: Home Cell
Can I leave you a message? At Home ? Y / N - Your Cell? Y / N
You may contact me by e-mail and by text regarding your appointments.
Please initial here _____ if you give me the permission to return your e-mails and texts.*
* Please note: E-mail and text correspondence are not considered to be confidential media of communication.

Emergency Contact

Name: _____Phone: _____

Client Information

Your Gender: M / F

Age: _____

Your Occupation: _____

Education: _____

Please check the following:

Marital/Relationship status:

___ Never Married

____Domestic Partnership

____ Married

____Separated

____Divorced

____Widowed

Negeen Moussavian
THERAPY

Years Married (Together): _____

Spouse's (Partner's) Name: _____

His / Her Age: _____

His / Her Education: _____

His /Her Occupation: _____

Children, their names and & Ages:

_____

Who referred you?

_____

Who do you presently live with?

_____

Is this working for you?

_____

What brought you here today?

_____

What are your goals for counseling?

_____

What do you consider to be some of your strengths?

_____

What do you consider to be some of your weaknesses?

_____

Do you have any fears or concerns about being in counseling?

_____

Have you experienced a traumatic event in recent years? If yes, please describe.

_____

Negeen Moussavian
THERAPY

_____

_____

_____

Are you experiencing stress in any of these areas?

Grief: _____

Work: _____

Relationships: _____

Legal: _____

Family: _____

Spiritually: _____

Financial: _____

School: _____

Other: _____

Who are the people you feel emotionally supported by?

Work: _____

Relationships: _____

Family: _____

Spiritually: _____

Professionals: _____

School: _____

Other: _____

What is your use of substances? (approximately)

Substance	**Amount**	**Frequency**	**Last Use**
Alcohol			

Negeen Moussavian
THERAPY

Prescription			
Recreational Drugs			
Other			

Do you have a history of:

Seizures _____ Hallucinations _____ Blackouts _____ Scary Thoughts _____

Confusion _____ Tremors _____ Other _____

Previous Counseling Experience – Outpatient / Inpatient

When	With Whom	Where	Frequency	Diagnosis	Date of Termination

Negeen Moussavian
THERAPY

Are you currently working with any other doctor, therapist, psychologist, group, etc.? Y / N

If Yes, explain:

_____

May I contact them?

Y / N Name: _____Phone: _____

Y / N Name: _____ Phone: _____

Have you taken any psychiatric medications in the past at any time?

Antidepressants: _____

Antianxiety: _____

Antipsychotics: _____

Medical History

Current Medical Problems:

_____

Name of Physician:

_____

Could I contact them to coordinate your care, if necessary? Y / N

Phone #: _____

Are you currently taking any medications? For What Dosage

_____

_____

Have you experienced any of the following in the past year?

[ ] Fatigue / Sleep Disturbance: _____

[ ] Depression / Extreme Sadness: _____

[ ] Loss of Interest in Daily Activity: _____

[ ] Panic / Anxiety: _____

[ ] Decreased Concentration / Memory Loss: _____

Negeen Moussavian
THERAPY

Have you experienced any of the following in the past year? *(continued)*

[ ] Mood Swings: _____

[ ] Weight Gain/Loss: _____

[ ] Excessive Worthlessness/ Guilt: _____

[ ] Paranoia/ Obsessive Behavior: _____

[ ] Isolation/ Loneliness: _____

Have you ever attempted or seriously considered suicide? If so, When?

_____

Have you ever engaged in self-mutilation/cutting/burning? Y / N Specify how?

_____

Have you any concerns about your sexuality with your partner or for your partner or for yourself? Y / N

Any:

[ ] Heart Palpitation [ ] Difficulty Breathing [ ] Stomach Problem [ ] Diabetes

[ ] Other _____

Any disabilities including visual / auditory? Y / N Describe:

_____

Your family of origin information:

Member	**Name**	**Age**	**Education**	**Occupation**	**History of Mental Illness** ***if any***
Father					
Mother					
Brother or Sister					

Brother or Sister					