Deborah Essex, M.F.T.
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Client Intake Form

Client Information:

Last Name_____ First Name _____ Middle _____

Telephone: home _____
work _____
cell phones _____ e-mail _____

Address _____
_____

Age_____ Birth Date ___/___/_____

Employer/School: _____

Living Situation- who do you live with in your home:

Name _____ Age____ Relation _____
Name _____ Age____ Relation _____
Name _____ Age____ Relation _____
Name _____ Age____ Relation _____

Reason for Seeking Treatment:

_____

_____

_____

List problems at home (if applicable):

List problem with family members (if applicable):

List problems at work/school (if applicable):

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Check if any of the following as been a problem in the last 6 months. Make additional comments, where applicable:

___ problems with anger

___ problems with fears/anxieties

___ problems with activity level (hyperactivity/ inactivity)

___ problems with eating (weight gain/ weight loss)

___ problems with sleep (insomnia, night wakings, over-sleeping)

___ problems with concentration, or memory

___ problems with completing tasks

___ problems with mood (please specify, depressed, angry anxious):

___ communication problems (please specify):

___ other problems with behavior (please specify)

Medical History:
Significant or unusual medical history including major illnesses, injuries, hospital stays, diseases or disabilities:

_____

_____

_____

Primary Care Physician: _____ Location _____

Current Medications: _____

Emergency Contact:

Name _____ Telephone (cell #s)_____

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Mental Health History:
Prior treatment with mental health practitioner (Reason for seeking help, name of provider, dates/frequency seen, response to treatment):

_____

_____

Psychiatric Medication, if prescribed (type, date first taken, dosage, response, side effects):

_____

_____

List other close family members involved in mental health treatment (incl. reasons):

_____

Family/genetic history of mental illness (e.g.; depression, ADHD, anxiety, addiction,etc.):

_____

_____

Therapeutic Goals:
What are you seeking to improve with therapy?

_____

_____

What do you see as your major strengths and weaknesses?

_____

_____

_____