In The Moment Counseling, LLC
Effective, Compassionate Psychotherapy for Adults

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Client Intake Form

Thank you for taking the time to openly and honestly answer the questions below. Your genuine responses are appreciated, as all information provided will assist your therapist to better understand your presenting issues and need for treatment. If there are any questions you do not feel comfortable answering at this point in time, please indicate this on the particular section of the form. Thank you.

Name: _____ **Date**: _____

Briefly describe the reason(s) you are seeking psychotherapy at this time:

Current symptom checklist:

Please indicate the severity of each current symptom by checking the appropriate box.

Never = I have never experienced this symptom
Past = I am currently not experiencing this symptom, but have in the past
Mild = Mildly impacts quality of life, but no significant impairment of day-to-day functioning.
Moderate = Significantly impacts quality of life and/or day-to-day functioning.
Severe = Profoundly impacts quality of life and/or day-to-day functioning.

Symptom	Never	Past	Mild	Moderate	Severe
Depressed mood	☐	☐	☐	☐	☐
Suicidal thoughts	☐	☐	☐	☐	☐
Self-harm	☐	☐	☐	☐	☐
Appetite disturbance	☐	☐	☐	☐	☐
Sleep disturbance	☐	☐	☐	☐	☐
Fatigue/low energy	☐	☐	☐	☐	☐
Poor concentration	☐	☐	☐	☐	☐
Worthlessness	☐	☐	☐	☐	☐
Guilt/shame	☐	☐	☐	☐	☐
Hopelessness	☐	☐	☐	☐	☐
Social Isolation	☐	☐	☐	☐	☐
Mood swings	☐	☐	☐	☐	☐
Elevated mood	☐	☐	☐	☐	☐
Anger/Irritability	☐	☐	☐	☐	☐
Aggressive behaviors	☐	☐	☐	☐	☐
Relationship difficulties	☐	☐	☐	☐	☐

Symptom	Never	Past	Mild	Moderate	Severe
Hyperactivity	☐	☐	☐	☐	☐
Anxiety/worry/fear	☐	☐	☐	☐	☐
Panic attacks	☐	☐	☐	☐	☐
Phobias	☐	☐	☐	☐	☐
Obsessive thoughts	☐	☐	☐	☐	☐
Compulsive behaviors	☐	☐	☐	☐	☐
Delusions	☐	☐	☐	☐	☐
Hallucinations	☐	☐	☐	☐	☐
Dissociation	☐	☐	☐	☐	☐
Anorexia	☐	☐	☐	☐	☐
Binge Eating	☐	☐	☐	☐	☐
Purging/vomiting	☐	☐	☐	☐	☐
Laxative/diuretic use	☐	☐	☐	☐	☐
Substance use/abuse	☐	☐	☐	☐	☐
Sexual dysfunction	☐	☐	☐	☐	☐
Grief	☐	☐	☐	☐	☐

Past Psychiatric History:

Question	No	Yes
Are you currently being prescribed psychiatric medication(s)?	☐	☐
*If **yes**, please specify medication(s) being prescribed and by whom:*		
Have you been prescribed psychiatric medication(s) in the past?	☐	☐
*If **yes**, please specify date(s), medication(s) prescribed and by whom:*		
Have you ever been seen at an ER for psychiatric reasons or admitted to a psychiatric inpatient facility?	☐	☐
*If **yes**, please specify dates, duration of treatment, locations treated and reason for treatment:*		
Have you ever received outpatient mental health/counseling services?	☐	☐
*If **yes**, please specify date(s), treatment facility, duration of treatment and reason for treatment:*		
Have you ever attempted suicide?	☐	☐
*If **yes**, please specify number of attempts, approximate date or age at attempt and method:*		
Have you ever intentionally harmed yourself, such as cutting, burning, bruising or other methods?	☐	☐
*If **yes**, please specify age when this behavior first began, type of self-harm behavior and frequency of behavior:*		
If **yes**, *do you currently engage in self-harming behavior?*	☐	☐
*If **no**, when was the last episode of self-harming behavior:*		
Have you ever intentionally harmed someone else, such as physical fights, assaults, etc?	☐	☐
*If **yes**, please specify who, frequency, method of harm and outcome:*		

Medical History:

Question	No	Yes
How would you describe your current overall physical health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor		
Do you have any current medical conditions, chronic illness or physical complaints, such as asthma, hypertension, diabetes, seizure disorder, thyroid problems, fibromyalgia, cancer, etc?	☐	☐
*If **yes**, please specify:*		
Have you had any past serious medical conditions, surgeries or accidents?	☐	☐
*If **yes**, please specify:*		
Do you have a primary care physician?	☐	☐
*If **yes**, please specify name and location:*		
Are you currently being prescribed medical medication(s)?	☐	☐
*If **yes**, please specify:*		

Developmental History:

Question	No	Yes
To your knowledge, did your mother have any complications during pregnancy or labor and delivery?	☐	☐
*If **yes**, please specify:*		
To your knowledge, did you reach all of your developmental milestones (i.e. walking, talking) within the normal range?	☐	☐
*If **yes**, please specify:*		
Are you adopted?	☐	☐
*If **yes**, at what age?*		
Did you experience any trauma or significant loss (i.e. the death of a parent, instability with caregivers) during your early childhood?	☐	☐
*If **yes**, please specify:*		

Family History:

Question	No	Yes
Do you have a family history of any of the following: *(if yes, please specify whom and provide brief details)*		
Chronic or serious medical conditions	☐	☐
Mental health issues	☐	☐
Alcohol abuse	☐	☐
Drug abuse	☐	☐

Relationship History:

Question	No	Yes
Are you currently married or involved in a significant intimate relationship?	☐	☐
*If **yes**, for how long:*		
Please briefly describe any significant past relationships:		

Trauma History:

Question	No	Yes
Have you witnessed or experienced any past or current trauma, such as childhood abuse or domestic violence?	☐	☐

*If **yes**, check all that apply:*

- ☐ Childhood sexual abuse
- ☐ Childhood emotional abuse and/or neglect
- ☐ Victim of domestic violence
- ☐ Physical assault during adolescence/adulth
- ☐ Childhood physical abuse
- ☐ Witness of domestic violence
- ☐ Sexual assault/rape during adolescence/adulthood

Substance Use History:

Question	No	Yes
Do you currently use alcohol?	☐	☐
*If **yes**, please specify age of first use, type, frequency and amount:*		
Do you currently use tobacco?	☐	☐
*If **yes**, please specify age of first use, type, frequency and amount:*		
Do you currently use drugs, such as marijuana, cocaine, or methamphetamine?	☐	☐
*If **yes**, please specify type, age of first use, frequency and amount:*		
Do you have a past history of alcohol or drug misuse/abuse/dependence?	☐	☐
*If **yes**, please provide details:*		
Have you experienced any legal problems due to alcohol and/or drug use, such as DUI?	☐	☐
*If **yes**, please specify the type of legal problems experienced:*		
Have you experienced any other negative consequences from alcohol and/or drug use, such as fights, blackouts, seizures, or withdrawal symptoms?	☐	☐
*If **yes**, please provide details:*		
Do you have current involvement, or past experience, with substance abuse treatment, such as detox, rehabilitation programs or 12-step groups?	☐	☐
*If **yes**, please provide details:*		

Educational History:

Question	No	Yes
Are you currently enrolled in school?	☐	☐
*If **yes**, where and for what:*		
What is your highest educational level?		

Vocational History:

Question	No	Yes
Are you currently employed outside of the home?	☐	☐
*If **yes**, please list current occupation/employer?*		
How long have you been in this position?		
Are you satisfied with your current employment?	☐	☐
Please indicate any past pertinent vocational history:		

Legal History:

Question	No	Yes
Are you currently involved in the judicial system, such as being on probation?	☐	☐
*If **yes**, please provide details:*		
Do you have any past legal history, such as being arrested, convicted of a crime or incarcerated?	☐	☐
*If **yes**, please provide details:*		

Military History:

Question	No	Yes
Are you currently involved with the military?	☐	☐
*If **yes**, please provide details:*		
Do you have past military involvement?	☐	☐
*If **yes**, please provide details:*		

Cultural History:

Question	No	Yes
Please describe your sexual orientation (i.e. heterosexual, homosexual, bisexual, transgendered, etc):		
Please describe your ethnic and/or cultural background:		
Do you identify with any particular spiritual or religious affiliation?	☐	☐
*If **yes**, please describe:*		

Please describe skills, resources and/or strengths you feel you possess:

Please indicate what goals you would like to accomplish by seeking therapy at this time, or in other words, what are you hoping to gain by seeking therapy at this time?

Is there anything else important about yourself or your current situation that you would like for me to know at this time?

Thank you for your time and attention in completing this intake form. I look forward to working with you!