HYGEIA COUNSELING SERVICES℠
a d u l t   p s y c h o t h e r a p y

CLIENT INTAKE FORM (Regular Version)

Proper treatment requires as much historical information as possible. Please fill this out to the best of your abilities. Completing this outside of session will maximize our therapy time. We will likely go over some of the answers.

ONLINE INTAKE INFORMATION – PART I (Pages 1 to 3):
Please complete this section if you have not filled out the Biographical Information Form online through Therapy Appointment. Otherwise, please just write in your name and proceed to page 4 "Additional Information" section.

NAME:____

Symptoms

Please list any symptoms (ex: lonely, anxiety) or concerns that you have been feeling lately. In addition, what brings you to therapy?

What stresses or life changes have you experienced lately?

Psychiatric History

Have you seen a therapist in the past?

YEAR	PROBLEM	THERAPIST OR CLINIC	HOW LONG?

Your Family Growing Up?

Relationship	First Name	Personality / Mental Health Issues
Mother		
Father		
Other:		
Other:		

About Your Childhood
Please list issues experienced in childhood that were important to your well-being at the time.

Who Lives With You Now?

Relationship	First Name	Personality / Mental Health Issues

Where are you currently living?: Dorm/Campus Apt. Apartment House With Relatives Other

Relationship History:

[Note: Please count domestic partner or other long-term relationships of equal importance to you as a marriage.]

How many times have you been married? Never Married Times:_______

How old were you at the time of your marriages?:____

Briefly describe any problems in your current or past marriages or cohabitation relationships:

Education & Occupation:

Are you currently: Working In School Both Neither

Highest level of education so far?:____________________________

What is (or was) your major or favorite subject?:____

How many hours per week are you working?:______ In what field do you usually work?:_____________________

What is your current or most recent job title?:_____________________________________

Briefly describe what you like and dislike about your employment or school:

Home Life:

How do you spend personal time? (hobbies, sports, clubs, groups, family activities, etc.)

How many contacts do you have each month with friends outside of work or school?________________

Who can you talk with about personal feelings or private matters?:

Are you satisfied with your romantic life?

Briefly describe what you like and dislike about your current romantic and friendship lives:

Health:

Circle each accident or illness you have experienced:

Recent Surgery	Head Injury	Seizures	Thyroid Problem	Drug/Alcohol Treatment	Neurological Disorders
Chronic Pain	Headaches	Diabetes	Hormone Problems	Infertility	Miscarriages

List any other chronic health problems you may have:

How many hours do you sleep in an average night?:____ Bed Time:______ Wake Time:________

Do you exercise? How much? How often?

When was your last physical?

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ADDITIONAL INFORMATION – PART II:

Please complete this section regardless of whether or not you completed an online Biographical Information form.

Psychosocial History

Marital Status (circle one): married domestic-partner divorced separated single

Children's names & ages (if any):____

Please list people who are emotionally supportive of you:

Do you have a history of interaction with the law? If so, what:_______________________________

Name & age of parents (if deceased, cause & age at death):_______________________________

Nature of relationship with parents (past & current):_______________________________

Sibling's names & ages (if any):____

Are family members local? Who?____

Medication/Drug History

Names, dosage, purposes, & notable side effects of current medication:

Past psychiatric medications & purposes (including ADHD, sleep, & anti-depressants from somatic physician):

Frequency and quantity of caffeinated beverages, nicotine products, alcohol, illegal drugs, and marijuana:

Alcohol & Drug Use:

When thinking about drug use, include illegal drug use and the use of prescription drug use other than prescribed. Please circle YES or NO for each question.

1. Have you ever felt that you ought to cut down on your drinking or drug use? | YES / NO

2. Have people annoyed you by criticizing your drinking or drug use? | YES / NO

3. Have you ever felt bad or guilty about your drinking or drug use? | YES / NO

4. Have you ever had a drink or used drugs first thing in the morning to steady your | YES / NO
   nerves or get rid of a hangover?

Special Factors

Are you currently suicidal or homicidal?____

Do you have a history of either one?____

Are you court-ordered or otherwise required to receive treatment?_______________________________

Do you have a history of self-mutilation such as cutting or burning yourself?_______________________

Have you ever been diagnosed with, or thought to have, anorexia or bulimia?_______________________

Do you have weapons in your home?____

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