COLLABORATIVE INSIGHTS, LLC
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Client Intake Form - Individuals

Client information

Name (First, MI, Last) ▼ | Birth date (month/day/year) ▼ / / | Age ▼

If the client is a minor, provide the name of the parent or guardian ▼

Home address (number and street) ▼ | Apt. no. ▼ | City/town ▼ | State ▼ | Zip ▼

Phone number where you may be reached and messages left ▼
◯ Cell ◯ Home ◯ Work

Email address ▼

Marital status: ▼
◯ Never married ◯ Domestic partnership ◯ Married ◯ Separated ◯ Divorced ◯ Widowed

Name of spouse/partner (if any) ▼

Please list close family members and significant relationships ▼

Name	Relationship to you	Age	Gender	Where living?

Emergency contact

Name ▼ | Phone ▼ | Relationship ▼

Employment

Occupation ▼ | Employer ▼

Education

Highest level attained ▼
◯ Elementary school ◯ High school ◯ Community college ◯ Apprenticeship ◯ Undergraduate ◯ Master's
◯ Middle school ◯ G.E.D. ◯ Trade school ◯ Some university ◯ Some graduate ◯ Doctorate / JD / MD

Medical/Mental health info

Name of primary care physician ▼ | Phone ▼ | Date of last visit ▼ / /

Name of psychiatrist (if any) ▼ | Phone ▼ | Date of last visit ▼ / /

How is your health, presently? ▼
◯ Excellent ◯ Very good ◯ Good ◯ Just OK ◯ Poor ◯ Very poor

Please list any health problems that you're currently experiencing ► ----------

Medical/Mental health info (continued)

Please list any sleep problems you are currently experiencing ►

Please list any issues with your appetite or eating patterns ►

Have you participated in counseling before? ▼	If yes, when and why? ▼
◯ Yes ◯ No	
Have you ever been hospitalized for mental health reasons or for substance abuse? ▼	If yes, for what specific reason? ▼
◯ Yes ◯ No	

What significant life changes or stressful events have you experienced recently? ►

Please list all medications (prescription and over-the counter) you are taking ▼

Name of medication	Dosage	Reason for taking	Prescribed by

Please indicate which of the following areas are currently concerns for you. Check all that apply. ▼

- ☐ Abuse survivor issues
- ☐ Adjusting to change/ Life transitions
- ☐ Aggressive behavior
- ☐ Anger
- ☐ Anxiety
- ☐ Bipolar
- ☐ Blended family issues
- ☐ Chronic pain
- ☐ Communication issues
- ☐ Depression
- ☐ Divorce adjustment
- ☐ Domestic violence
- ☐ Eating & food issues
- ☐ Emotional abuse
- ☐ Emptiness
- ☐ End-of-life adjustment
- ☐ Family of origin issues
- ☐ Family problems
- ☐ Fatigue
- ☐ Fertility issues
- ☐ Financial problems
- ☐ Grief & loss
- ☐ Habits
- ☐ Impulsivity
- ☐ Infidelity/Affair recovery
- ☐ Insomnia/Sleep problems
- ☐ Isolation (emotional or social)
- ☐ Legal issues
- ☐ Life purpose/Meaning
- ☐ Post-traumatic stress
- ☐ Pregnancy problems
- ☐ Relationship issues
- ☐ Self-care
- ☐ Self-doubt
- ☐ Self-esteem issues
- ☐ Marriage problems
- ☐ Mood disturbance
- ☐ Mood swings
- ☐ Obsessions
- ☐ Parenting issues
- ☐ Panic/Panic attacks
- ☐ Phobias/Fears
- ☐ Physical abuse
- ☐ Poor concentration
- ☐ Self- harming behaviors
- ☐ Sensitivity to criticism
- ☐ Sexual abuse
- ☐ Shame
- ☐ Social anxiety
- ☐ Spiritual problems
- ☐ Stress
- ☐ Substance abuse
- ☐ Suicidal (thoughts, feelings or behaviors)
- ☐ Trauma
- ☐ Trust issues
- ☐ Work stress
- ☐ Other (please specify below)

What would you like to accomplish during your time in therapy? ►

What else would you like me to know about you? ►

Please sign and date ▼

Client signature ► _____ Date ► _____

Parent/Guardian signature ► _____ Date ► _____