Kyra F. Riddell
MA in Counseling Somatic Psychology
Licensed Marriage and Family Therapist
Lic.98921

Client Intake Form

Name:_____ Date:_____

This form is intended to save both you and your therapist time and is in the interest of providing you with the best service possible. All information on this form is considered confidential.

Personal Data:

Address: _____

_____

Cell or Home Phone: _____ Best time to call: _____

Work Phone: _____ Best time to call: _____

Which number(s) may I call and leave a message? Please Circle: Home Cell Work

Email: _____

Age: _____ Birthdate: _____Gender Identity: _____

Ethnicity: _____

Language(s): _____

Occupation: _____

Referred by: _____

Person To Be Contacted In Case of Emergency:

Name:_____

Address: _____

Telephone: _____

Relationship to you: _____

FAMILY DATA:

Marital or Relationship Status:

___ Single ___Cohabitating If Married, or In a Relationship, How Long?: _____

___ In a Relationship ___ Separated Previous Marriages?: _____

___ Married ___ Divorced If Divorced, How Long?: _____

____ Widowed

List below the people living with you:

Name	Relationship	Age

List any additional immediate or significant family members not living with you:

Name	Relationship	Age

MEDICAL AND MENTAL HEALTH:

Current Physician or Office/Clinic: _____

Phone: _____ Last Visit: _____

Current Medical Problems: _____

_____

Significant Past Medical Problems: _____

_____

Current Psychiatrist: _____ Phone: _____

Medications Being Taken: _____

Last Prescribed or Frequency of Refills: _____

Previous History of Mental Health Care:

Start Date	Type of Services	Reason	Duration

Previous Hospitalizations (Medical or Psychiatric):

Date	Hospital Name	Reason	Length of Stay

Other Serious Illnesses:

Date	Nature of Condition	Duration

Significant Trauma(s) and Year Occurred:

Serious Injuries, Accidents, Death of a Significant Other, Witness of a Death, Victim of Abuse or Violation, or Childhood Traumas: alcoholic or addict parent or caregiver, neglect, chaotic or abusive environment, sibling abuse, incest, divorce, homelessness, moved a lot, bullied, developmental delay, or others not listed:

LIFESTYLE:

How would you rate your health? Please circle

Poor / Unsatisfactory / Satisfactory / Good / Very Good

Please list any specific health problems you are experiencing:

_____

How frequently do you generally exercise? What types of activities do you participate in?

_____

How would you rate your sleeping habits? Please circle

Poor / Unsatisfactory / Satisfactory / Good / Very Good

Please list any specific sleep problems you are experiencing:

_____

How would you rate your eating habits? Please circle

Poor / Unsatisfactory / Satisfactory / Good / Very Good

Please list any difficulty you are having with your appetite or eating patterns:

_____

Habits	*Amount Currently Using*	*Most Ever Used*
Coffee (cups per day)		
Cigarettes (packs per day)		
Alcohol (drinks per day/week/month)		

Have you ever abused illegal, over the counter, or prescription drugs? If yes, please describe:

Substances	Amount	Frequency	When? (First use, Last use)

Briefly State Reasons for Seeking Counseling:

_____

_____

_____

_____

Please check all areas affected. Place TWO check marks to indicate the most challenging areas.

____ Feeling nervous or anxious
____ Under Pressure & feeling stressed
____ Afraid of being on your own
____ Feeling angry much of the time
____ Difficulty expressing emotions
____ Feeling inferior to others
____ Lacking self confidence
____ Feeling unhappy or sad
____ Feeling lonely
____ Experiencing guilty feelings
____ Lack motivation to pursue interests
____ Feeling down on yourself
____ Thoughts of taking own life
____ Concerns about emotional stability
____ Feeling cut-off from your emotions
____ Wondering "Who Am I"
____ Having difficulty being honest /open
____ Difficulty making decisions
____ Feeling confused much of the time
____ Difficulty controlling your thoughts
____ Difficulties trusting your partner

____ Thoughts about having an affair
____ Past affairs
____ Difficulties communicating with partner
____ Often fight or argue with partner
____ Feeling misunderstood
____ Feelings related to having been molested
____ Concerns about physical health
____ Feeling fat or hating your body
____ Difficulties with weight control
____ Excessive use of alcohol and/or drugs
____ Being suspicious of others
____ Difficulty with work
____ Concerns about finances
____ Having a hard time keeping or making friends
____ Feeling pressured by others
____ Feeling controlled/manipulated
____ Marital Problems
____ Issues with the family or children
____ Difficulties in sexual relationship