# Individual Therapy Intake Form

*Adults only | Private-pay practice | In-person and telehealth*

**Welcome**

Please complete this form as fully as you comfortably can. You may leave a question blank and discuss it with me in session.

## Contact Information

**Date:** _____

**Legal name:** _____

**Preferred name:** _____

**Date of birth:** _____

**Address:** _____

**City, State, ZIP:** _____

**Phone:** _____

**Email:** _____

**Preferred contact method:** ☐ Phone call ☐ Email

**May I leave a voicemail identifying the practice?** ☐ Yes ☐ No

**Any communication or privacy restrictions I should know about:** _____

## Your Current Life

**Current work, school, caregiving, retirement or primary role:** _____

**How is this area of your life affecting you right now?**

_____

_____

**Relationship status:** _____

**Who currently lives in your home?**

_____

**Please list children, dependents, or other significant relationships you would like me to know about.**

_____

_____

## What Brings You Here

**What is bringing you to therapy now?**

_____

_____

_____

**What would make therapy feel worthwhile to you?**

_____

_____

**What is going well in your life right now, even if it feels small?**

_____

_____

**What would you like to understand, change, or experience differently?**

_____

## Current and Past Concerns

| Area | Please check any current concern or past experience that still affects you |
|---|---|
| **Emotional** | ☐ Anxiety or excessive worry ☐ Depression or low mood ☐ Anger or irritability ☐ Excessive guilt ☐ Obsessive or intrusive thoughts ☐ Low self-esteem ☐ Feeling stuck or unfulfilled |
| **Relationships** | ☐ Couple or marriage concerns ☐ Communication difficulties ☐ Divorce or separation adjustment ☐ Infidelity or trust concerns ☐ Sexual or intimacy concerns ☐ Blended-family concerns ☐ Extended-family concerns ☐ Loneliness or disconnection |
| **Life and Functioning** | ☐ Stress or overwhelm ☐ Career or school concerns ☐ Life transition ☐ Grief or loss ☐ Sleep difficulties ☐ Difficulty relaxing ☐ Appetite changes ☐ Spiritual concerns |
| **Health and Safety** | ☐ Alcohol or substance concerns ☐ Chronic illness or pain ☐ Fears or phobias ☐ Past assault or abuse ☐ Current relationship-safety concerns ☐ Thoughts of self-harm or suicide ☐ Other |

## Safety and Support

**Have you had thoughts of harming yourself or not wanting to live?** ☐ Never ☐ In the past ☐ Recently ☐ Currently

**Do you currently feel safe at home and in your relationships?** ☐ Yes ☐ No ☐ Unsure

**Is there anything related to your safety that would be important for me to know before we meet?**

**Important**

If you are in immediate danger or believe you may act on thoughts of harming yourself or someone else, call 911 or go to the nearest emergency department. This form is not monitored continuously.

## Strengths and Coping

**What do you consider to be your personal strengths?**

**What do you like most about yourself?**

**What helps you cope when you feel stressed or overwhelmed?**

**Who or what helps you feel supported?**

## Medical, Medication, and Substance Information

**Are there medical conditions, health concerns, pain, hormonal changes, or recent health events that may be affecting you?**

**Primary care physician:** _____

**Phone:** _____

**Date of last medical examination:** _____

**Psychiatrist or prescribing provider, if applicable:** _____

**Phone:** _____

**Are you currently taking prescribed medications?** ☐ No ☐ Yes

**If yes, please list medication, dose, and purpose if known.**

**Do you drink alcohol?** ☐ No ☐ Yes

**If yes, how often and how much?**

**Do you use cannabis or other recreational substances?** ☐ No ☐ Yes

**If yes, what do you use and how often?**

## Previous and Current Care

**Have you previously participated in therapy or counseling?** ☐ No ☐ Yes

**When and for how long:** _____

**What concerns were addressed, and what was helpful or unhelpful?**

**Previous therapist:** _____

**Current therapist, psychiatrist, physician, or other provider relevant to your care:** _

**Would you like to discuss coordinating care with another provider?**

## Emergency Contact and Referral

**Emergency contact name:** _____

**Relationship:** _____

**Phone:** _____

**How did you hear about the practice?** ☐ Self ☐ Internet ☐ Friend or relative ☐ Professional referral ☐ Other

**Is there anything else you would like me to know before we meet?**

I look forward to working together. Thank you.