JONATHAN S. SCHREIBER, LMFT
P.O. Box 58
Mansfield Center, CT 06250
Phone: 860-931-5054 / Fax: 888-502-4995

CLIENT INTAKE FORM

Client Name:_____ DOB:_____ Today's Date:_____

Primary reason(s) for seeking therapy: _____

_____

What do you consider to be your and/or your family's strengths?_____

_____

Please list all members of your household

Name	Relationship	Age	DOB
1.			
2.			
3.			
4.			
5.			

THERAPY HISTORY ☐ Yes ☐ None (If yes, please describe below)

Dates		From whom? (name, address, phone)	For what?	Results of treatment
From	To			

MEDICATIONS TAKEN ☐ Current ☐ Past ☐ None (If current or past, please describe below)

Dates		Name of medication	For what?	Prescribed by whom?	Effect? (Helpfulness? Side effects?)
From	To				

HEALTH

How would you rate your current physical health? (circle) Poor 1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 Excellent

How would you rate your current sleeping habits? (circle) Poor 1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 Excellent

How often do you exercise? (circle) Rarely 1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 Daily

Please list any specific health problems you are currently experiencing:

EDUCATION INFO (Highest level of education attained)	☐ Grade _____ ☐ High School ☐ Some college	☐ College degree ☐ Some grad school ☐ Grad degree	☐ Post graduate work

EMPLOYMENT INFO				
Dates		Name of employer(s)	Job title or duties	Reason for leaving
From	To			

Please check off the statements below as they apply to you and/or your family:

	Self	Spouse	Mother	Father	Siblings	Other Relations
Problems with aggression and defiance as a child						
Problems with attention and impulse control as a child						
Learning disabilities						
Failed to graduate high school						
Mental retardation						
Psychosis or Schizophrenia						
Depression for greater than two weeks						
Anxiety disorder						
Tics or Tourette's						
Alcohol/Substance abuse						
Arrests (legal troubles)						
Verbal/Emotional abuse						
Physical abuse						
Sexual abuse						
Self-Harm (e.g., cutting, burning, etc.)						
Suicide attempt(s)						
Other (anything significant not mentioned above)						

Do you consider yourself to be spiritual and/or religious? ☐ Yes ☐ No

If yes, please describe your faith or belief: _____

Something not mentioned in the rest of this form that would be important for me to know about you and/or your family is…

_____

_____