NORTHLAND
Behavioral Health & Wellness

Client Intake

PERSONAL INFORMATION

Name:_____ Date:_____

Parent/Legal Guardian (if minor): _____

Address:_____

Cell Phone: _____ Home Phone: _____

Email: _____

DOB: _____ Age: _____ Preferred Pronouns: _____

Gender:

☐ Male ☐ Transgender (MTF or FTM)

☐ Female ☐ Gender Queer Other: _____

Sexual Orientation:

☐ Heterosexual ☐ Homosexual

☐ Bisexual Other: _____

Marital Status:

☐ Single ☐ Divorced ☐ Domestic Partnership

☐ Married ☐ Separated ☐ Widowed

Present Living Arrangement:

☐ Alone ☐ Spouse/Partner ☐ Family ☐ Friends Other: _____

Emergency Contact:

Name: _____ Relationship: _____

Cell Phone: _____ Home Phone: _____

Address: _____

How did you hear about us? (If applicable):

_____

GENERAL & MENTAL HEALTH HISTORY

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.?)

☐ No ☐ Yes, previous therapist/ practitioner: _____

Have you ever been prescribed psychiatric medication? ☐ No ☐ Yes

If yes, please list:

_____

_____

_____

Are you currently taking any prescription medication? ☐ No ☐ Yes

If yes, please list:

_____

_____

_____

Any Medical Concerns? _____

_____

Exercise per week: _____ Alcohol per week: _____

How often do you engage in recreational drug use? ☐ Daily ☐ Weekly ☐ Monthly ☐ Infrequently ☐ Never

Daily tobacco use: _____ Daily Caffeine use: _____

Briefly describe why you are seeking treatment currently:

_____

_____

_____

Are you involved in any legal difficulties? If yes, explain: _____

_____

Are there any cultural or spiritual needs related to your therapy? If yes, explain:

Briefly describe any history of trauma (divorce, illness, accidents, abuse, etc.):

Have you attempted suicide in the past? If yes, explain: _____

Are you currently suicidal? If yes, explain: _____

Are currently homicidal or experiencing aggressive thoughts/behaviors towards others? If yes, explain: _____

Please Check any Symptoms you have been experiencing in the past 6 months:

☐ Depression ☐ Anxiety ☐ Panic Attacks ☐ Suicidal Thoughts ☐ Suicidal Behaviors

☐ Self-Injury ☐ Isolation ☐ Hopelessness ☐ Numbness (Physical and/or Emotional)

☐ Difficulty Falling Asleep ☐ Poor Sleep (Describe): _____

☐ Changes in appetite (Increase? or Decrease?) ☐ Weight Gain ☐ Excessive dieting

☐ Compulsive Exercising ☐ Mood Swings ☐ Irritability ☐ Grief

Difficulties: ☐ Maintaining work ☐ House responsibilities ☐ Making Decision

☐ Maintaining Relationships ☐ Getting Along with others

ADDITIONAL INFORMATION

Are you currently employed? ☐ No ☐ Yes

If yes, what is your current employment situation?

Do you enjoy your work? Is there anything stressful about your current work?

Are you in a romantic relationship? ☐ No ☐ Yes

How would you rate your relationship On a Scale of 1-10 (with 1 being poor and 10 being exceptional?) _____

What do you consider to be some of your strengths? _____

What do you consider to be some of your weaknesses? _____

What would you like to get out of therapy? _____