**CLIENT INTAKE FORM**

**Dr. Dan Gottlieb**

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Your name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_

Please take your time in providing the following information. The questions are designed to help me begin to understand you so that our time together can be as productive as possible. All information provided is confidential.

PLEASE MARK YOUR RESPONSE WITH AN “X” AND TYPE ANSWERS ON THIS DOCUMENT. EMAIL YOUR RESPONSE TO ME AT LEAST 48 HOURS BEFORE OUR FIRST SESSION.

Have you previously received any type of mental health services?

\_\_ Yes \_\_ No

**If yes, then**:

* which of the following (Please mark “X”):

\_\_ Psychotherapy

\_\_ Medication

\_\_ Outpatient Hospitalizations

\_\_ Inpatient Hospitalization

* please provide:

Name of provider or facility: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dates of treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Reason for treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe what you are looking for in therapy. Can you describe what you believe is the cause of your distress? (Type your answer in the space below)

What areas of your life have been affected by this problem?

Describe any major losses or traumas you may have experienced:

Have you experienced any significant life changes or stressful events over this past year?

What do you believe you need to facilitate healing?

**Family History**

When and where were you born? \_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any parents and siblings. Please use additional space on the back if needed.

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** | **Age** | **Relationship** | **Whether they are living or deceased, how would you describe your relationship?** |
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With whom did you live while growing up? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In the section below identify if there is a **family history** of any of the following. If yes, please indicate the family member’s relationship to you in the space provided (father, grandmother, uncle, etc.)

|  |  |  |
| --- | --- | --- |
| **Condition** | **Please enter “Y” or “N”** | **List Family Member** |
| Alcohol/Substance Abuse |  |   |
| Anxiety |  |   |
| Depression |  |   |
| Domestic Violence |  |   |
| Sexual Abuse |  |   |
| Eating Disorders |  |   |
| Obesity |  |   |
| Obsessive Compulsive Disorder |  |   |
| Schizophrenia |  |   |
| Suicide Attempts |  |   |
| Other diagnosed mental health condition? |  |   |

Your Marital Status: (Please Mark “X”)

\_\_ Never Married

\_\_ Domestic Partner

\_\_ Married

\_\_ Separated

\_\_ Divorced -- For how long? \_\_\_\_\_\_\_\_\_\_\_

\_\_ Widowed: Please provide your partner’s name and year deceased:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If married or in a long-term relationship, what is your partner’s name?: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

On a scale of 1-10 (best), how would you rate your relationship? \_\_\_\_

Please list any **children**, their names, and ages:

|  |  |  |
| --- | --- | --- |
| **Name** | **Age** | **Comments** |
|   |   |   |
|   |   |   |
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|   |   |   |

**Physical Health**

Please list any medications. Be sure to include the condition, as some medications are prescribed for off-label use. Continue on the back if needed, or provide a separate list.

|  |  |  |  |
| --- | --- | --- | --- |
| **Medication** | **Dosage** | **Condition** | **Date Began/Stopped** |
|   |   |   |   |
|   |   |   |   |
|   |   |   |   |
|   |   |   |   |
|   |   |   |   |
|   |   |   |   |
|   |   |   |   |
|   |   |   |   |

Prescribing provider and contact information:

Name:

Specialty:

Facility:

Phone, email, or Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How would you rate your current physical health?

\_\_ Poor

\_\_ Unsatisfactory

\_\_ Satisfactory

\_\_ Good

\_\_ Very Good

Please list any specific health problems and their impact on your wellbeing:

How would you rate your current sleeping habits?

\_\_ Poor

\_\_ Unsatisfactory

\_\_ Satisfactory

\_\_ Good

\_\_ Very Good

If you are having problems, in which phase of sleep are you experiencing issues?

\_\_ Falling asleep

\_\_ Staying asleep

\_\_ Awakening too early

\_\_ Sleep apnea

\_\_ Please list any other specific sleep problems you are currently experiencing:

How many times per week, if any, do you generally exercise? \_\_\_

What types of exercise?: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently experiencing any chronic pain? \_\_ No \_\_ Yes

If yes, please describe:

Please describe current and previous use of alcohol and recreational drugs:

**Additional Information**

Are you employed? \_\_ Yes \_\_ No

If yes, what is your occupation? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What do you enjoy about your work? If retired, are you enjoying your life?

What do you enjoy doing in your free time? What do you do to relax?

Do you consider yourself to be spiritual or religious? If so, briefly describe:

What do you consider to be some of your strengths?

What do you consider your areas that need growth?