Envision Therapy, PLLC
Client Intake Form

Client name: _____ Preferred name: _____
Guardian's name (if applicable):_____
Date of birth:_____ Age: _____
Address: _____
Home Phone:_____ May we leave a message? □ Yes □ No
Cell/Work/Other Phone: _____ May we leave a message? □ Yes □ No
Email: _____ May we leave a message? □ Yes □ No
**Please note: Email is not considered to be a confidential medium of communication*

By initialing below I am authorizing my provider to contact me through the following electronic means for scheduling or other administrative purposes:
□ Email □ Text □ Voicemail

Emergency contact information:
Name: _____ Relationship: _____
Address: _____ Phone: _____

Race/Ethnicity: _____ (Prefer not to say □)
Sexual orientation: _____(Prefer not to say □)
Gender identity & pronouns: _____ (Prefer not to say □)
Relationship status [Married, Single, Divorced, Other]: _____
Children (number and ages): _____
Religion/Spirituality: _____ (Prefer not to say □)
Highest level of education completed: _____
Profession/Employment status: _____
Housing status: _____

How did you find me as your therapist (e.g., friend recommendation, doctor referral, Google search, provider directory search, etc.)?

_____

What is the reason you are coming in for counseling? Is there something specific, such as a particular event? When did this start or happen? How is your life affected by this issue? Please be as detailed as you can.

_____

_____

_____

What are your goals for our work together?

_____

_____

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Mental health history/ treatment history:
Have you seen a mental health professional in the past (therapist, psychologist, psychiatrist, school counselor)? If so, please specify dates, reason for treatment, and any diagnosis:

_____

_____

Are you currently taking any psychiatric medications? (yes / no)
If so, please specify: _____
Name of prescribing physician: _____

Have you ever been hospitalized for a psychiatric issue, eating disorder, or substance use?

- If yes, please answer the corresponding questions:
  - Where (hospital/institution, city/state):_____
  - When did this happen? _____
  - For what reason were you hospitalized? _____
  - Length of stay: _____
  - Diagnosis, if any: _____

No, I have not been hospitalized for a psychiatric issue, eating disorder, or substance use.

Do you have, or have you ever had, a problem with self-harm (e.g., cutting, scratching, hair-pulling, etc.)?
Yes
No
If yes, please describe: _____

Do you have, or have you ever had, suicidal thoughts?
If yes, when?
No, I have never had suicidal thoughts.

Have you ever attempted suicide? Please list all attempts and your age when each happened, starting from the most recent event to the oldest.
If yes, when?
If yes, by what means did you attempt?
No, I have never attempted suicide.

Do you have, or have you ever had thoughts or urges to harm someone else or damage their property?
Yes
No

Is there a history of mental illness in your family?
If yes, please describe (relationship to family member, nature of mental illness):

- No, there is not a history of mental illness in my family.

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Sleep and rest:
On a scale from 0-10 (0= very poor, 10= the very best), how would you rate your sleep? _____
How many hours of sleep do you get in an average night? _____
Do you feel rested upon waking? _____

Diet and eating habits:
What do you find yourself typically eating?__
Do you eat regular meals throughout the day?
Do you think your meals are balanced?_____

Substance use:
Do you smoke cigarettes or use any nicotine products? If so, what and how often?
- □ Yes
- □ No, I don't use any nicotine products

Do you currently drink alcohol? If so, how often?
- □ 1-2 times per month
- □ 1-2 times per week
- □ 3-4 times per week
- □ 4+ times per week
- □ Daily
- □ No, I do not drink alcohol

Have you or any friends or family members felt concerned about your alcohol use?
- □ Yes, please specify: _____
- □ No

Do you currently use any recreational drugs?
- □ Yes, please specify (type and frequency): _____
- □ No

More About You:
What do you do for fun and enjoyment?

What do you do to manage stress or cope with a difficult day?

Who would consider your closest sources of support or your "inner circle"?

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Please check any of the following you have experienced in the past six months:

- ☐ Increased appetite
- ☐ Decreased appetite
- ☐ Trouble concentrating
- ☐ Difficulty sleeping
- ☐ Excessive sleep
- ☐ Low motivation
- ☐ Isolation from others
- ☐ Fatigue/low energy
- ☐ Low self-esteem
- ☐ Depressed mood
- ☐ Tearful or crying spells
- ☐ Anxiety
- ☐ Fear
- ☐ Hopelessness
- ☐ Panic

Other:

Please check any of the following that apply:

- ☐ Headache
- ☐ High blood pressure
- ☐ Gastritis, esophagitis, ulcer
- ☐ Hormone-related problems
- ☐ Head injury
- ☐ Angina or chest pain
- ☐ Irritable bowel
- ☐ Chronic pain
- ☐ Loss of consciousness
- ☐ Heart attack
- ☐ Bone or joint problems
- ☐ Seizures
- ☐ Kidney-related issues
- ☐ Chronic fatigue
- ☐ Other:
- ☐ Dizziness
- ☐ Faintness
- ☐ Heart valve problems
- ☐ Urinary tract problems
- ☐ Fibromyalgia
- ☐ Numbness & tingling
- ☐ Shortness of breath
- ☐ Diabetes
- ☐ Hepatitis
- ☐ Asthma
- ☐ Arthritis
- ☐ Thyroid issues
- ☐ HIV/AIDS
- ☐ Cancer

Is there anything else you would like me to know?