Psychotherapy Intake Form

Client Information

Name:

Date of Birth:

Gender:

Address:

Phone Number:

Email Address:

Date of Consultation:

Medical History

Do you have any medical conditions?

Are you currently taking any medications or supplements?

Have you had any surgeries or hospitalizations?

Mental Health History

Have you ever been diagnosed with a mental health condition?

Have you received therapy or counseling before?

Have you experienced any traumatic events?

Current Symptoms

Please describe your current symptoms or concerns:

When did they start?

How often do they occur?

How severe are they?

Goals for Therapy

What would you like to achieve through therapy?

What are your hopes and expectations for working with a therapist?

Signature of the Patient over Name and Date