Individual Client Intake Form

A gentle place to begin sharing your story

Full name:

Preferred name:

Date:

Date of birth:

Pronouns (optional):

Phone:

Email:

Preferred contact:

Address:

May I leave a voicemail?

☐ Yes ☐ No

Emergency contact - name, relationship, and phone:

Welcome

Thank you for taking the time to complete this form. These questions will help me understand what brings you to therapy, what has shaped you, and what you hope to gain from our work together.

There are no right or wrong answers. Please share only what feels comfortable; you may skip any question and we can talk about it together.

1 / You & Your Life

Begin wherever feels most natural.

How would you describe yourself and where you are in your life?

What currently feels difficult, stressful, or unresolved, and what prompted you to seek therapy now?

What is currently going well or helping you feel grounded?

Emotional Well-Being & Relationships

2 / Emotional Well-Being & Relationships

Which feelings or experiences have been present recently?

- ☐ Anxiety or worry
- ☐ Anger or irritability
- ☐ Loneliness
- ☐ Numbness or disconnection
- ☐ Difficulty concentrating
- ☐ Joy or gratitude
- ☐ Sadness or low mood
- ☐ Guilt or shame
- ☐ Feeling overwhelmed
- ☐ Grief or loss
- ☐ Panic
- ☐ Other: _____

How do these concerns affect your daily life, relationships, work, or well-being?

When you are struggling, what do you tend to do? What helps?

Who are the important people in your life? How would you describe your relationships and support system?

Are there relationship patterns or concerns you would like to explore?

Health, Previous Support & Safety

3 / Health, Previous Support & Safety

These questions help me understand how to support you thoughtfully and safely.

Please share relevant health concerns, medications or supplements, and anything about sleep, appetite, energy, or substance use that may affect your well-being:

Have you participated in therapy or other healing work before?

- [ ] Yes
- [ ] No

If yes, what was helpful and what would you want to be different this time?

Have you received a mental health diagnosis or psychiatric medication? If so, what would be helpful for me to know?

Safety check

- [ ] I currently feel safe at home
- [ ] I have experienced trauma, abuse, or violence
- [ ] I am concerned about someone hurting or controlling me
- [ ] I have had thoughts of not wanting to be alive
- [ ] I have had thoughts of harming myself
- [ ] I have harmed myself in the past
- [ ] I have had thoughts of harming someone else
- [ ] I would rather discuss this together

If you checked a safety concern, is it current? What helps you stay safe?

If you are in immediate danger or may act on thoughts of harm, call 911 or go to the nearest emergency room. In the U.S., call or text 988 for crisis support.

Looking Forward

4 / Looking Forward

If therapy were helpful, what might feel different in your life six months from now?

What would you like to understand, change, heal, or strengthen?

What are your three most important hopes or goals for therapy?

What strengths have helped you through difficult times?

What would help our work together feel safe, meaningful, and worthwhile?

Is there anything else you would like me to know, or anything you feel nervous or hopeful about?