Center for Sexual Health
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CLIENT COMPREHENSIVE THERAPY INTAKE FORM

Clients please fill out as completely as possible

Today's date: _____

Full name: (First) (Middle) (Last)	**DOB:** **Age:**	**Gender/Gender Identity:**
Ethnicity (optional): ☐ Caucasian ☐ African American ☐ Latino/Latina/Latinx ☐ Native American ☐ Asian American ☐ Multi-racial ☐ Other(Describe):		
How did you find out about CSH?		

1. PRESENTING PROBLEM: Please define briefly the problems, challenges, and/or concerns for which you are seeking our services.

2. GOALS: Please list what it is you want to accomplish for yourself and/or your relationship by participating in our program.

3. PERSONAL PRIVATE INFORMATION: Are there any important things about yourself that you would like us to know in order for us to best serve you (e.g., issues that might cause you shame, secrets, religious concerns, etc.)

4. RELATIONSHIP: Are you in a sexual relationship? ☐ Yes ☐ Unsure ☐ No
If yes, or unsure, please consider if there are important things (sexual or non-sexual) about you that you do not feel free to tell your partner at the present time. Please indicate briefly what they are.
(These will not be shared with your partner unless you decide to share them yourself)

5. Below are a number of common mental health concerns for which people seek help. Please indicate which have been a concern for you WITHIN THE LAST SIX (6) MONTHS, by checking "yes" if any of the words describe a concern for you. Check "No" only if any of the words have not been an issue for you.

Emotional Functioning			**Physical Functioning**			**Sexual Functioning**		
☐ yes	☐ no	Feel flat, empty, numb	☐ yes	☐ no	Eating problems	☐ yes	☐ no	Loss of sexual desire
☐ yes	☐ no	Depressed, hopeless	☐ yes	☐ no	Fatigue, tiredness	☐ yes	☐ no	Performance difficulties
☐ yes	☐ no	Suicidal thoughts and/or behavior	☐ yes	☐ no	Sleeping difficulties	☐ yes	☐ no	Unsafe sexual behavior
☐ yes	☐ no	Sadness and/or crying	☐ yes	☐ no	weight loss	☐ yes	☐ no	Sexual compulsivity
☐ yes	☐ no	Irritable/moody	☐ yes	☐ no	overweight	☐ yes	☐ no	History of sexual abuse
☐ yes	☐ no	Anger and/or rage	☐ yes	☐ no	Alcohol abuse	☐ yes	☐ no	Sexual orientation concerns
☐ yes	☐ no	Anxiety/worry	☐ yes	☐ no	Drug abuse	☐ yes	☐ no	Genital image/size concerns
☐ yes	☐ no	Fear and/or dread	☐ yes	☐ no	Pain and/or nausea	☐ yes	☐ no	Gender concerns
☐ yes	☐ no	Nervous, shaky	☐ yes	☐ no	Serious illness and/or health problems	☐ yes	☐ no	STD, HIV, AIDS concerns
☐ yes	☐ no	Self-harm thoughts/behaviors				☐ yes	☐ no	Disturbing fantasies/dreams
Self-Image and Coping Issues			**Mental Functioning**			**Relationship and Life**		
☐ yes	☐ no	Avoidance/Denial	☐ yes	☐ no	Memory problems	☐ yes	☐ no	Conflict, fighting
☐ yes	☐ no	Compulsivity	☐ yes	☐ no	Easily distracted	☐ yes	☐ no	Isolation, loneliness
☐ yes	☐ no	Shy or sensitive	☐ yes	☐ no	Buzzing in ears	☐ yes	☐ no	Being honest about myself
☐ yes	☐ no	Low self-esteem	☐ yes	☐ no	Voices inside head	☐ yes	☐ no	Death and dying concerns
☐ yes	☐ no	Self-hatred, guilt, shame	☐ yes	☐ no	Troubling thoughts	☐ yes	☐ no	Living more effectively
☐ yes	☐ no	Feel ugly, poor body image	☐ yes	☐ no	Feel paranoid	☐ yes	☐ no	Grieving
			☐ yes	☐ no	Troubling dreams	☐ yes	☐ no	Work or family problems

Other current concerns (Please specify) _____
_____

PSYCHIATRIC/MENTAL HEALTH/CHEMICAL DEPENDENCY HISTORY

6. ***PREVIOUS THERAPISTS (most recent first)*****:**

☐ ***NONE***

Name of therapist/clinic: _____
Address and Phone: _____
Date Therapy Began: _____ Date Therapy Ended: _____
Diagnoses Given: _____
Issues Addressed and outcome:
_____
_____

Name of therapist/clinic: _____
Address and Phone: _____
Date Therapy Began: _____ Date Therapy Ended: _____
Diagnoses Given: _____
Issues Addressed and outcome:
_____
_____

Name of therapist/clinic: _____
Address and Phone: _____
Date Therapy Began: _____ Date Therapy Ended: _____

Diagnoses Given: _____
Issues Addressed and outcome:
_____
_____

***7. PSYCHIATRY SERVICES*:**

☐ ***NONE***

Name of psychiatrist/clinic: _____
Address and Phone: _____
Date Therapy Began: _____ Date Therapy Ended: _____
Diagnoses Given: _____
Issues Addressed and outcome:
_____
_____

8. PSYCHIATRIC HOSPITALIZATIONS ☐*NONE*

Approx Dates & Duration:		Where:		Reason/Outcome:	
Approx Dates & Duration:		Where:		Reason/Outcome:	
Approx Dates & Duration:		Where:		Reason/Outcome:	

9. PSYCHIATRIC MEDICATIONS ☐ *NONE*

Current Prescriptions	**Dosage**	**Purpose of Medication**	**Approximate dates/Duration**	**Prescribed by *(physician/ clinic)***
Past Prescriptions	**Dosage**	**Purpose of Medication**	**Approximate dates/Duration**	

Please list any over-the-counter Medications: _____
_____
_____

Medication Allergies ☐Yes ☐No	**Type of reaction**

10. ALCOHOL/DRUG USE/ABUSE

Alcohol Use: ☐ Yes ☐ No
Average number of drinks per day: ____ per week: ____
Drugs: ☐ Yes ☐ No

Name of drug(s):
Average amount per day: ____ per week: ____

Any history of alcohol or drug overuse/abuse/dependency? ☐ Yes ☐ No
Please describe: _____
_____

Please make sure any chemical dependency treatment is listed above.

MEDICAL HISTORY

11. Primary Physician/Clinic: _____
Address and Phone: _____
_____

MEDICAL PROBLEMS (DESCRIBE BELOW) ☐ **NO MEDICAL PROBLEMS**	
Surgeries	
Medications	
Medical Problems/Illnesses	
Contraceptive Use	

SOCIAL HISTORY

12. PARENTS

Name	***Age***	***Health***	***Mental Health***	***Substance Abuse History & Currently***
Parents education and occupation:				
Mother:				
Father:				
Describe relationship with mother and father as a child & as an adult:				
Mother:				
Father:				

13. SIBLINGS ☐No Siblings

Name	*Age*	*Health/Mental Health*	*Substance Abuse History & Currently*	*Relationship*

Which siblings are you close to? _____

14. FAMILY/RELATIONSHIPS

Your current Relationship status:	☐Single ☐Married/Partnered ☐Remarried ☐Separated ☐Widowed ☐Divorced (# of times & dates_____)			
	If married or partnered how long? _____ Years			
Current Relationship	***Name***	***Age***	***Occupation & Schooling***	**How well do you relate with your partner or significant other** (explain)

MEMBERS OF YOUR CURRENT/PRESENT HOUSEHOLD

☐**I live alone**

Name	*Age*	*Relationship*	*Occupation/School*

Describe your current living situation (dual residence, house, apt, group home, etc.):	
Describe any current housing problems:	

15. ABUSE HISTORY ☐*None*

Type	Current	Past	Who abused you?	When/ Duration	Outcome
Sexual	☐	☐			
	☐	☐			
Physical	☐	☐			
Emotional/ Verbal	☐	☐			
Have you ever been witness to domestic violence?					☐ **Yes** ☐ **No Describe:**
Have you ever been a victim of domestic violence?					☐ **Yes** ☐ **No Describe:**
Have you ever been physically, emotionally, verbally, or sexually abusive to others?					☐ **Yes** ☐ **No Describe:**

16. PREVIOUS SIGNIFICANT SEXUAL RELATIONSHIPS ☐*None*

First name and gender	Length of relationship & approx. dates	Why ended & by whom
1.		
2.		
3.		
4.		

17. CHILDREN ☐*None*

First Name & Gender	Age	First Name & Gender	Age
1.		4.	
2.		5.	
3.		6.	

Describe your relationship with your children:	

18. EDUCATION

Highest Grade	*Field of Study*	*Name of School*	*Year of graduation*

19. EMPLOYMENT

☐ ***Not currently employed***

Current (Name, Job Title)	**Duration/ dates**	**Does your current position satisfy you…**
		☐ Intellectually ☐ Emotionally ☐ Physically ☐ Financially
Past Employment		**Why did you leave? Describe**

Do you feel you experienced any deterioration in your job/school performance due to the problem you are seeking counsel for? ☐ **Yes** ☐ **No** *(if yes, check all that apply)*

☐ Attendance ☐ Conflicts with supervisors ☐ Conflicts with co-workers
☐ Erratic behaviors ☐ Accidents/safety violations

Rate your level of motivation in your current job:	☐ Low ☐ Medium ☐ High
Do you or your family have financial concerns?	☐ Yes ☐ No (Describe)

Rate your satisfaction with the state of your finances:

☐ **1**	☐ **2**	☐ **3**	☐ **4**	☐ **5**
Very Dissatisfied	**Dissatisfied**	**Neither**	**Satisfied**	**Very Satisfied**

Please explain your satisfaction/dissatisfaction with finances: _____

_____

20. MILITARY SERVICE

☐ ***None***

Branch	*Rank*	*Year*	*Duration*	*Outcome*

21. MAJOR CHANGES IN THE LAST YEAR

Move/relocation	☐ Yes ☐ No Describe:
Blended family issues	☐ Yes ☐ No Describe:

Death of a family member or friend	☐ Yes ☐ No Describe:
Childbirth/Adoption	☐ Yes ☐ No Describe:
Job changes	☐ Yes ☐ No Describe:
Relationship issues	☐ Yes ☐ No Describe:
Other:	☐ Yes ☐ No Describe:

22. LEGAL ISSUES ☐ *None*

	Arrests/Convictions/Lawsuits *(Most recent first):*	**Date**	**Outcome**
1.			
2.			
3.			

23. SPIRITUALITY & CULTURE

Is there anything you would like us to know about your culture?	
About your spirituality or religion?	

24. LEISURE/SOCIAL ACTIVITIES

Exercise & recreational sports	
Interests, Hobbies, & Clubs	
Friends (none, few, many) & Social life	

25. STRENGTHS/WEAKNESSES

What do you consider your major strengths?	***What do you consider your major limitations/weaknesses?***

26. Any additional comments or issues you want to add?

Thank you for taking the time to complete this form. It will be helpful in your assessment and treatment.