**Lisa Ades, PhD & Associates, PLLC**

5100 Wisconsin Ave., NW ~ Suite 300 ~ Washington, DC 20016

**CLIENT INTAKE FORM**

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

First Middle Last

SS# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age \_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_\_ Zip Code\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Do we have permission to call you? Yes No

Cell Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Do we have permission to call you? Yes No

E-mail \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Do we have permission to e-mail you? Yes No

Sex/Gender \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Race/Ethnicity \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship Status: Single Significant Relationship Married/Partnered Separated Divorced Widowed Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Children: yes no Please list their ages and genders: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Disabilities/Illnesses (if any) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Financial Status: Comfortable Some Stress Severe Stress \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Spiritual/Religious Affiliation (if any) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you employed outside the home? \_\_\_\_\_ What kind of job? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you a student? \_\_\_\_\_ Where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Your degree/major?\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EMERGENCY CONTACT**

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to You \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**REFERRAL SOURCE**

How did you hear about our practice? (check all that apply)

Self Flyer/Pamphlet Website Google Parent/Family Member Friend/Colleague

Other Counselor/Therapist Medical Provider Treatment Program

Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

OK to thank referrer? Yes No Name of Referrer (person or agency) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address of Referrer (if known) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone # of Referrer (if known) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CHECKLIST OF CONCERNS/REASONS FOR SEEKING THERAPY SERVICES**

Please mark all of the items below that apply to you. You may add other items at the end if needed. Also feel free to add a note or details in the space next to any of the concerns that you checked.

Addictions & Obsessions/Compulsions (thoughts or actions that repeat)

Alcohol use

Cleanliness

Counting

Eating (bingeing, purging, overeating, undereating)

Dieting/exercise

Drug use (including prescription and over-the-counter meds, street drugs)

Gambling

Hoarding

Love addiction (i.e., can’t go without being in a relationship, sequentially or concurrently)

Perfectionism

Pornography

Sexual activity, hypersexualized behaviors

Shopping/spending

Shoplifting

Smoking/tobacco use

Weight/body image

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age, Gender & Sexuality Concerns

Concerns about your age, aging, age discrimination

Gender discrimination

Gender identity

Sexual orientation

Sexual dysfunction

Sexual harassment/exploitation

Sexual health

Sexual risk-taking

Sexual satisfaction

Beliefs/Values, Ethical Issues, & Spiritual/Religious Concerns

Confusion about beliefs, values

Moral/ethical issues

Sense of foreshortened future

Spiritual/religious concerns

Cognitive Functioning

Attention span/concentration problems

Confusion & thought disorganization

Decision-making, indecision, avoidance

Delusions (false ideas)

Judgment problems, risk-taking

Memory problems

Suspiciousness/paranoia

Emotion & Mood Regulation

Anger, hostility, irritability, low frustration tolerance

Aggression, violence

Anxiety, nervousness, tension

Depression, low mood, crying, sadness, low motivation

Emptiness

Fears/phobias \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Flashbacks of traumatic event(s)

Grief/mourning of deaths, losses, divorce, etc.

Guilt

Helplessness/powerlessness

Homesickness

Hopelessness

Hyperactivity (extremely high energy)

Hypersensitivity (easily hurt or upset; feel things very deeply)

Hypervigilance (constantly on high alert, jumpy and reactive)

Impulsiveness, loss of control, outbursts

Inferiority feelings

Loss of interest/motivation

Loneliness

Mood swings

Hypersensitivity

Nightmares/distressing dreams

Numb feelings/no feelings

Panic or anxiety attacks

Pessimism, negativity

Stress, stress management, stress disorder, tension

Sudden behavioral changes

Withdrawal, isolating

Family Problems

Addictions of family members (please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Care of elders

Housework/chores—quality, schedules, sharing duties

Marital conflict/distance/disappointments; infidelity/affairs; separation/divorce; remarriage

Parenting, child management, single parenting, child custody

Extended-family stressors

Financial

Money troubles, debt, low income

Other financial concerns \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Harm of Self/Others

Suicidal thoughts (please describe) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Suicidal action/attempt (please describe) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Homicidal thoughts/actions (please describe) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Thoughts of self-injury (e.g., cutting or any behaviors designed to release tension or overwhelming feelings)

(please describe) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Self-injury behaviors (please describe) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Interpersonal Functioning in Relationships

Assertiveness issues

Codependence/dependence

Commitment/intimacy issues

Problems with friends, relatives, or coworkers

Problems in romantic relationship(s)

Self-centeredness

Self-esteeem/self-confidence

Shyness, social phobia

Oversensitivity to criticism, rejection

Unreliable/irresponsible

Unstable/unreliable partner history

Judicial/Legal Issues (Against you or filed by you)

Legal matters, charges, suits

Criminal charges

Judicial/police/court actions

Physical Health

Chronic illness or disease \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Chronic pain

Disability \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fatigue, tiredness, low energy

Headaches, migraines

Hormonal or menstrual problems (e.g., PMS, menopause) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other medical concerns or physical problems \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Self-neglect, poor self-care

Sleep problems

oversleeping too little sleep insomnia early waking nightmares

School & Work

Academics—performance/study skills

Attention, concentration, distractibility

Career/job dissatisfaction

Career goals and decisions, career transitions

Childhood school experiences

Employment/Unemployment

Failure

Procrastination, work inhibitions, motivation challenges

Trouble keeping a job

Workaholism/overworking

Trauma/Abuse (Past or Present)

Childhood abuse or neglect (verbal, emotional, physical, psychological, sexual)

Exposure to family violence

Exposure to animal cruelty

Psychological abuse/torture

Relationship/domestic violence

Sexual assault/unwanted sex

Sexual harassment/exploitation

Stalking/cyberstalking victimization

War/military conflict exposure

Other exposure to violence/abuse/trauma \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any current crisis situations? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any other concerns or issues?

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

\* If you would find it helpful to write a narrative statement about the concerns that are motivating you to seek treatment at this time, feel free to write on the back of these forms or attach a separate sheet.

Please look back over the concerns you have checked off and choose the three for which you most want help:

1)

2)

3)

Please estimate the severity of your problems:

mildly upsetting moderately severe severe very severe incapacitating

Please list your typical strategies for reducing stress: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

Finally, please list your greatest strengths: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Thank you for filling this out.**