

# THERAPY INTAKE FORM

(All information is confidential and used solely for therapeutic purposes.)

## 1. Client Information

- **Full Name:** \_\_\_\_\_
- **Date of Birth:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_ (DD/MM/YYYY)
- **Age:** \_\_\_\_\_
- **Gender:**  Male  Female  Other: \_\_\_\_\_
- **Preferred Pronouns:**  He/Him  She/Her  They/Them  Other: \_\_\_\_\_
- **Home Address:** \_\_\_\_\_
- **City:** \_\_\_\_\_ **Postcode:** \_\_\_\_\_
- **Phone Number:** \_\_\_\_\_
- **Email:** \_\_\_\_\_

## 2. Emergency Contact

- **Full Name:** \_\_\_\_\_
- **Relationship to Client:** \_\_\_\_\_
- **Phone Number:** \_\_\_\_\_

## 3. GP Details

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- **Surgery Name:** \_\_\_\_\_
- **Doctor's Name:** \_\_\_\_\_
- **Address:** \_\_\_\_\_
- **Phone Number:** \_\_\_\_\_
- **Email:** \_\_\_\_\_

## 3. Insurance Information (if applicable)

- **Insurance Provider:** \_\_\_\_\_
- **Policy Number:** \_\_\_\_\_
- **Name of Policyholder (if different from client):** \_\_\_\_\_
- **Relationship to Policyholder:**  Self  Spouse  Parent  Other: \_\_\_\_\_

## 4. Referral Information

- **How did you hear about this service?**  GP  Self-Referral  Friend/Family   
Other: \_\_\_\_\_
- **Have you had therapy before?**  Yes  No
  - If yes, what type? \_\_\_\_\_
  - Was it helpful?  Yes  No

## 5. Presenting Issues & Goals

- **What are the main difficulties you would like to address in therapy?**
- **How long have you been experiencing these issues?** \_\_\_\_\_
- **What do you hope to achieve through therapy?**

## 6. Medical & Mental Health History

- **Do you have any diagnosed medical conditions?**  Yes  No
  - If yes, please specify: \_\_\_\_\_
- **Are you currently taking any medication?**  Yes  No
  - If yes, list medications and dosages: \_\_\_\_\_
- **Do you have any allergies?**  Yes  No
  - If yes, specify: \_\_\_\_\_
- **Have you been diagnosed with any mental health conditions?**  Yes  No
  - If yes, please specify: \_\_\_\_\_
- **Have you ever been hospitalised for psychiatric reasons?**  Yes  No
  - If yes, please provide details: \_\_\_\_\_

## 7. Risk Assessment

- **Have you experienced thoughts of self-harm or suicide?**  Yes  No
- **If yes, are these current or in the past?**  Current  Past
- **Have you ever attempted suicide?**  Yes  No
  - If yes, when? \_\_\_\_\_
- **Do you have thoughts of harming others?**  Yes  No
- **Do you currently engage in any substance use (alcohol, drugs)?**  Yes  No
  - If yes, please specify type and frequency: \_\_\_\_\_

## 8. Lifestyle & Social Support

- **Relationship Status:**  Single  Married  Partnered  Divorced  Widowed
- **Do you have children?**  Yes  No
  - If yes, their ages: \_\_\_\_\_
- **Employment Status:**  Employed  Self-Employed  Unemployed  Retired  Student

- Do you have a strong support system (family, friends)?  Yes  No

## 9. Consent & Agreement

I confirm that the information provided in this form is accurate to the best of my knowledge. I understand that therapy is a collaborative process, and I agree to engage in the sessions with openness and commitment.

**Client Name:** \_\_\_\_\_

**Client Signature:** \_\_\_\_\_ **Date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Therapist Name:**

**Therapist Signature:** \_\_\_\_\_ **Date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_