Kristine Hutchison, PhD, LLC
4055 Executive Park Drive, Suite 210
Cincinnati, OH 45241
513-469-6226

Client Intake Form

Today's Date_____

Client Name_____ DOB_____

Address_____ City_____ State_____ Zip_____

Cell Phone_____ Home Phone_____

Email _____

Gender_____ Ethnicity_____

Marital Status ____ single ____ married ____ separated ____divorced ____ widowed

If separated, divorced, or widowed – how long_____

Employment Status: _____ Full Time _____Part-time _____Student _____Not working

Employer/School Name_____

Occupation_____ Work Phone_____

Spouse/Partner_____ DOB_____

Cell Phone_____ Home Phone _____

Email_____

Employer Name_____Occupation_____

Children/Step Children:

Name_____ DOB_____

Name_____ DOB_____

Name_____ DOB_____

Emergency Contact Name (if other than spouse/partner) _____

Relationship_____ Phone_____

Previous Counseling Treatment _____No _____Yes

If yes, Where_____ When_____

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Family Mental Health History

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (Check any that apply and list family member, e.g., siblings, parents, uncle, etc.)

Depression _____ Alcohol/Substance Abuse_____

Bipolar Disorder _____ Eating Disorders _____

Anxiety/Panic attacks_____ Learning Disabilities_____

Autism Spectrum_____ Schizophrenia_____

ADHD _____ Suicide Attempt(s) _____

OCD_____ Other_____

Social

Do you have: _____a lot of friends ___a few friends ___no friends

Would you like to change anything about your friendships? _____Yes _____No

If yes, please describe _____

Are you currently in a romantic relationship? _____No _____Yes

If Yes, how long_____

On a scale of 1-10, how would you rate the quality of your current relationship _____

Health

How is your physical health at present? _____Poor _____Satisfactory ____Very Good

If poor, please explain _____

Please list any ongoing health concerns (e.g. pain, headaches, hypertension, diabetes, etc.)

_____

_____

_____

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Please List All Current Medications, if applicable.

_____

_____

_____

_____

Do you have any allergies (environmental, food, medication)? ___No ____Yes

If yes, please explain _____

Do you have any problems with sleep? ____No _____Yes

If yes, please explain _____

Do you have any struggles with eating? ____No _____Yes

If yes, please explain _____

How often do you get any physical activity? _____

What kind? _____

Substance Use

How often do you drink alcohol? ____Daily ____Weekly ____Monthly _____Rarely ____Never

Amount consumed on each occasion? _____

Do you drink caffeinated beverages? ____No _____Yes

If yes, what kind? _____How much/often?_____

Do you smoke cigarettes? ____No ____Yes

If yes, how much/often?_____

Do you engage in recreational drug use? ____Daily ____Weekly ____ Monthly ____Rarely ____Never

What kind of drug(s)? _____ How much? _____

Have you previously been treated for substance abuse? ____No ____Yes

If yes, where _____ when _____

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Have you ever experienced any of the following (check all that apply)?

____Depressed mood
____Anxiety/Panic Attacks
____Hair pulling
____Mood swings
____Problems concentrating
____Hyperactive behavior
____Sleep disturbances
____Hallucinations
____Autism Spectrum Disorder
____Cutting oneself on purpose
____Speaking only around certain people
____Excessive defiant behaviors
____Frequent physical complaints
____Eating disorder
____Toileting struggles
____Repetitive thoughts (e.g., obsessions)
____Repetitive behaviors (e.g., checking or hand-washing)
____Learning disabilities
____Suicidal thoughts/attempts
____Homicidal thoughts

If yes to any of the above, please explain _____

_____

_____

_____

_____

_____

Additional Information

In the last year, have you experienced any significant life changes or stressors? ___No ____Yes

If yes, please explain:_____

_____

_____

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Have you ever been physically or sexually abused? _____No _____Yes

If yes, please explain: _____

_____

_____

What is your sexual orientation? _____

What do you consider to be your strengths? _____

_____

_____

What are your goals for therapy? _____

_____

_____

Any other information that you would like to share? _____

_____

_____

How did you hear about my practice? _____