CLIENT INTAKE FORM

Courtney Cohen, Therapy and Coaching
PA and NJ

(267) 918-1754
courtney@courtney-cohen.com

Date of first appointment:

Please take your time in providing the following information. The questions are designed to help me begin to understand you so that our time together can be as productive as possible. All information provided is confidential.

Referred by:

- ☐ My Website
- ☐ PsychologyToday
- ☐ Friend/Family:______________________________
- ☐ Social Media
- ☐ Other: _____________________________

Have you previously received any type of coaching/mental health services?

☐ Yes

☐ No

If yes, which of the following:

- ☐ Coaching
- ☐ Psychotherapy
- ☐ Medication
- ☐ Outpatient Hospitalizations
- ☐ Inpatient Hospitalization

If yes, please provide:
Name of provider or facility:____
Location:____
Approximate Dates of treatment:____

Reason for treatment:____

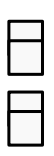
Briefly, what are you interested in working on together?

What areas of your life have been affected because of this issue?

Are you currently experiencing overwhelming sadness, grief or depression?

☐ Yes ☐ No

If yes, for approximately how long? ______________________



Are you currently experiencing anxiety, panic attacks or have any phobias?

☐ Yes ☐ No

If yes, when did you begin experiencing this? ____________________

Please describe any major losses or traumas you have experienced:

What significant life changes or stressful events have you experienced recently?

Family History

Where were you born? __________________________________

Where did you grow up? ________________________________

Please list your parents and siblings. Please use additional space on the back if needed

Name	Age	Relationship	Where do they live now?	If deceased, age and cause of death

Who did you live with while growing up? ____________________________________

Mother's occupation: __________________________________

Father's occupation: __________________________________

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

Condition	Please circle	List Family Member
Alcohol/Substance Abuse	yes/no	
Anxiety	yes/no	
Depression	yes/no	
Domestic Violence	yes/no	
Sexual Abuse	yes/no	
Eating Disorders	yes/no	
Obesity	yes/no	
Obsessive Compulsive Disorder	yes/no	
Schizophrenia	yes/no	
Suicide Attempts	yes/no	
Other diagnosed mental health condition?	yes/no : which was---	

Marital Status:

☐ Never Married. ☐ Domestic Partner ☐ Married ☐ Separated ☐Divorced -- For how long?__________

☐Widowed: Please provide your partners name and year deceased:

If married, how long have you been married for and what is your partners name:

On a scale of 1-10 (best), how would you rate your relationship?

Are you currently in a romantic relationship?

☐Yes -- How long?

☐No

On a scale of 1-10 (best), how would you rate your relationship?

Please list any children, their names, and ages:

☐
☐
☐

Physical Health

Please list any medications, herbs, or supplements. Be sure to include the condition, as some medications are prescribed for off-label use. Continue on the back if needed, or provide a separate list. If you have a complicated medical profile, please supply supporting documentation to be able to facilitate a comprehensive understanding of your health.

Medication/Supplement	Dosage	Condition	Date Began/Stopped

Prescribing provider and contact information:

Name:

Specialty:

Facility:

Phone, email, or Fax:

How would you rate your current physical health? ☐ Poor ☐ Unsatisfactory ☐Satisfactory ☐Good

☐Very Good

Please list any specific health problems you are currently experiencing:

How would you rate your current sleeping habits? ☐ Poor. ☐ Unsatisfactory

☐ Satisfactory
☐Good
☐Very Good

If you are having problems, in which phase of sleep are you experiencing issues?
☐Falling asleep
☐Staying asleep
☐Awakening early
☐Sleep apnea

Please list any other specific sleep problems you are currently experiencing:

How many times per week do you generally exercise?

What types of exercise do you participate in:

Are you currently experiencing any chronic pain?
No
Yes
If yes, please describe:
Please describe current use of alcohol, cigarettes, and/or recreational drugs:

Additional Information

What do you enjoy about your work (full-time homemaker included)? If retired, what did you enjoy about your work?

What do you find particularly stressful about your current or previous work?

What do you enjoy doing in your free time? What do you do to relax?

Do you consider yourself to be spiritual or religious? If yes, please describe your faith or belief:

What do you consider to be some of your strengths?

What do you consider to be some of your weakness?