Headway

General adult therapy intake form

CLIENT INFORMATION

Full Name _____

Date of Birth _____

Age _____

Pronouns _____

Gender Identity _____

Address _____

City/State/Zip _____

Email _____

Phone _____

OK to leave voicemail? _____

OK to text? _____

Preferred method of contact _____

Emergency contact name _____

Relationship _____

Phone _____

REFERRAL AND REASON FOR SEEKING SERVICES

How did you hear about this practice?

Briefly describe your reasons for seeking therapy

What are your goals for therapy?

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MENTAL HEALTH HISTORY

Have you ever seen a therapist or counselor before?
If yes, when and for what reason?

Have you ever been hospitalized for mental health concerns?:
If yes, please share:

CURRENT MENTAL HEALTH SYMPTOMS (CHECK ALL THAT APPLY)

- ☐ Anxiety
- ☐ Depression
- ☐ Trauma/Abuse
- ☐ Panic attacks
- ☐ Mood swings
- ☐ Sleep issues
- ☐ Suicidal thoughts
- ☐ Self-harm
- ☐ Substance use
- ☐ Relationship issues
- ☐ Stress
- ☐ Other:

Have you ever engaged in self harm? If yes, when?:

Have you ever attempted suicide? If yes, when?:

Have you experienced any major life changes or losses recently? If yes, please describe:

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MEDICAL HISTORY

Primary care provider name & contact _____

Current medical conditions or diagnoses: _____

Current medications (include dosage & reason) _____

Do you have any allergies (medication, food, etc.)? _____

SUBSTANCE USE

Do you currently use any of the following?

- ☐ Alcohol – How often?
- ☐ Tobacco – How often?
- ☐ Cannabis – How often?
- ☐ Other substances (prescription or recreational)

Have you ever had concerns about your substance use?

FAMILY & SOCIAL HISTORY

Relationship status

- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Partnered
- ☐ Widowed
- ☐ Other:

Children (names & ages)

Who lives in your household?

Support system (friends, family, community)

Religious or spiritual affiliation (if any)

Cultural or identity factors important to your care (race, ethnicity, gender identity, immigration, etc.)

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EMPLOYMENT & EDUCATION

Occupation _____

Employer _____

Currently working? _____

Highest level of education completed

- ☐ High school
- ☐ Some college
- ☐ College degree
- ☐ Graduate degree
- ☐ Other

INSURANCE & BILLING INFORMATION

Insurance provider _____

Policyholder name _____

Relationship to client _____

Member ID _____

Group # _____

Billing address _____

INFORMED CONSENT & SIGNATURE

I understand that the information provided in this form is confidential and will be used for treatment planning and care coordination. I understand that my therapist may discuss relevant information for clinical supervision or as required by law (e.g., danger to self/others, mandated reporting). I consent to participate in therapy services provided by this clinician.

Signature of Client (or Guardian if applicable) Date