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CLIENT INTAKE FORM

Date: _____ Client Name: _____

Date of Birth: _____ Age: _____ Gender: _____

Address: _____

City and State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Best Times to Reach: _____ Email: _____

May I contact you at home? (Y/N): _____ Leave a message at home (Y/N)? _____

May I contact you via email? (Y/N): _____ Best Way to Reach: _____

Occupation or School: _____

Annual Income: _____

Relationship Status (married, single, significant partner): _____

Ages and Living Arrangements of Children (if any): _____

Emergency Contact Name: _____

Phone Number: _____ Relationship to Client: _____

Are you currently under medical care (Y/N)? _____ If so, please explain: _____

Physician's Name and Phone Number: _____

Please list any medications, remedies or supplements you are currently taking: _____

Have you ever been under the care of a psychiatrist, psychologist or therapist (Y/N) ? _____

If so, please explain: _____

Please circle any of the following struggles that pertain to you:

- | | | |
|----------------------|------------------------|-----------------------------|
| Anxiety | Depression | Drug/Alcohol Use |
| Career/Life Choices | Eating Disorders | Fatigue |
| Fears/Phobias | Finances | Health Problems |
| Homicidal Thoughts | Insomnia | Self-Harm |
| Separation/Divorce | Sexual Problems | Spiritual/Religious Matters |
| Stress | Suicidal Thoughts | Troublesome Emotions |
| Troublesome Thoughts | Troubled Relationships | |

Anything else you would like me to know (e.g., your reasons for entering therapy, current struggles not listed above, your hopes and desires for our time together, activities you enjoy, etc.):

How did you find me? _____
