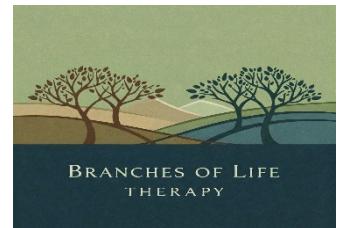


Branches of Life Therapy

Client Intake Form



Client Information

Full Name: _____

Parent/Guardian (if applicable): _____

Date of Birth: _____ **Age:** _____

Pronouns: _____

Phone Number: _____

Email Address: _____

Profession: _____

School/Grade Level (if applicable): _____

Address:

Emergency Contact

Name: _____

Relationship: _____

Phone Number: _____

Appointment & Communication

Preferred method of contact (check all that apply):

- Phone
- Email
- Text

May I leave a voicemail? Yes No

May I send appointment reminders? Yes No

Main Concerns

What brings you to therapy at this time?

How long have these concerns been affecting you?

Have you attended therapy before? Yes No

If yes, what was helpful/not helpful?

Mental Health & Wellness

Current symptoms (check all that apply):

- Anxiety or worry
- Depression or sadness
- Anger or irritability
- Stress or burnout
- Grief or loss
- Relationship or family concerns
- Trauma or past experiences
- Difficulty concentrating
- Sleep issues
- Other: _____

Are you currently taking any medications? Yes No

- If yes, list:

Do you have any diagnosed mental health conditions? Yes No

- If yes, please specify:

Substance use concerns? Yes No

If yes, describe:

Medical Information

Medical conditions/allergies to be aware of:

Strengths & Supports

What are some of your strengths?

Who do you consider part of your support system?

Goals for Therapy

What would you like to achieve through therapy?

Consent & Policies

I understand that therapy is a collaborative process and that I may ask questions at any time. I acknowledge that I have received and reviewed informed consent policies, including confidentiality, fees, and cancellation guidelines.

Signature: _____

Date: _____