

**Cynthia M. Thorp, Psy.D. (CA PSY23951; NV PY0674)**  
**1462 US Highway 395 (N) Gardnerville, NV 89410**  
**Ph: (775) 790-7771 Fax: (775) 392-3575**

**Client Intake Form**

Please fill out this biographical background form as completely as possible. It will help me in our work together. Information is confidential as outlined in the Agreement of Psychotherapy Form and the HIPPA Notice of Privacy Practices. If you do not desire to answer any question, please write "N/A." Please print or write clearly and bring this form with you to your first session.

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

DATE OF BIRTH/PLACE: \_\_\_\_\_ AGE: \_\_\_\_\_  
\_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE # HOME: \_\_\_\_\_ CELL: \_\_\_\_\_ WORK: \_\_\_\_\_

FOR CONFIDENTIAL/PRIVATE MSGS: \_\_\_\_\_ E-MAIL: \_\_\_\_\_

PERSON & PHONE NUMBER TO CALL IN EMERGENCY: \_\_\_\_\_

REFERRAL SOURCE: \_\_\_\_\_

OCCUPATION (former, if retired): \_\_\_\_\_

PRESENTING PROBLEM (be as specific as you can): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Estimate the severity of above problem:    Mild       Moderate       Severe       Very Severe (please circle)

Current marital status: \_\_\_ Living with someone: \_\_\_ Name: \_\_\_\_\_ Years: \_\_\_\_\_

PRESENT SPOUSE/PARTNER: \_\_\_\_\_

CHILDREN/STEP/GRANDCHILDREN (names/ages & brief statement on your relationship with the person:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

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PARENTS/STEP-PARENTS (name, age, or year of death, cause of death, occupation, personality, how did he or she treat you? Please provide a brief statement about the relationship):

Father: \_\_\_\_\_

\_\_\_\_\_

Mother: \_\_\_\_\_

\_\_\_\_\_

Step-parents: \_\_\_\_\_

\_\_\_\_\_

SIBLINGS: (name/age, if deceased: age and cause of death & brief statement about the relationship):

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

5. \_\_\_\_\_

MEDICAL DOCTORS (name/phone): \_\_\_\_\_

PAST/PRESENT MEDICAL CARE (major medical problems, surgeries, accidents, falls, illnesses):

\_\_\_\_\_

\_\_\_\_\_

Please specify the medication you are presently taking:

\_\_\_\_\_

PAST/PRESENT DRUG/ALCOHOL USE/ABUSE (AA, NA, treatments): \_\_\_\_\_

SUICIDE ATTEMPT(S) or VIOLENT BEHAVIOR (describe: age at time, reasons, circumstances, how, etc.):

\_\_\_\_\_

FAMILY MEDICAL HISTORY (describe any illness that runs in the family: cancer, epilepsy, etc.):

\_\_\_\_\_

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FRIENDSHIPS, COMMUNITY & SPIRITUALITY (describe quality, frequency, activities, etc.):

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PAST/PRESENT PSYCHOTHERAPY (specify: name, month/year, estimated number of sessions, initial reason for therapy, brief description of the relationship and how helpful it was):

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

DESCRIBE YOUR CHILDHOOD IN GENERAL (relationships with parents, siblings, others, school, neighborhoods, relocations, any school/behavioral problems, abusive/alcoholic parent):

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If PARENTS DIVORCED: Your age at the time: \_\_\_\_\_. Describe how it affected you at the time: \_\_\_\_\_

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FAMILY HISTORY OF MENTAL ILLNESS, ALCOHOLISM OR VIOLENCE (including suicide, depression, hospitalizations, abuse, etc.):

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ARE YOU INVOLVED IN ANY CURRENT OR PENDING CIVIL OR CRIMINAL LITIGATION(S), LAWSUIT(S) OR DIVORCE OR CUSTODY DISPUTE(S)? (If you answer yes, please explain):

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WHAT ARE YOUR MAIN WORRIES AND FEARS? \_\_\_\_\_

WHAT GIVES YOU THE MOST JOY OR PLEASURE IN YOUR LIFE? \_\_\_\_\_

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PLEASE INCLUDE ANY ADDITIONAL INFORMATION YOU WOULD LIKE ME TO KNOW ABOUT YOU AND YOUR SITUATION:

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