Nurtured Connections, LLC
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Intake Form

First Name: _____ Last Name: _____

Date of Birth: _____

Who will be involved in the treatment:

What brings you to my office?

How can I help?

Have you had any previous behavioral health treatment? ☐ **Yes** ☐ **No**

When, Where, How long, Provider name:

Are you currently taking any prescription or over-the-counter medications? ☐ **Yes** ☐ **No**

Please list name(s) of medication and dosage:

Does anyone in the family (blood relatives) suffer from any mental illness? ☐ **Yes** ☐ **No**

Please explain:

Do you/Does your child drink alcohol? ☐ **Yes** ☐ **No**

What type and frequency of drinking?

Do you/Does your child use recreational drugs? ☐ **Yes** ☐ **No**

What type and frequency of use:

Have you/your child ever suffered from, or been treated for, an eating disorder? ☐ **Yes** ☐ **No**

Please explain:

Have you/your child ever been arrested, charged with, or convicted of a crime? ☐ **Yes** ☐ **No**

Provide date and offense:

Educational History? (for parents): ☐ **Elementary** ☐ **High School Graduation/GRE**

- ☐ **Some College Graduate**
- ☐ **College Graduation** _____ (Degree - BA, MA, PhD)
- ☐ **Trade/Vocational School** _____ (Trade)
- ☐ **Current in school** _____ (Grade, Degree, Trade)

Do you/Does your child have any difficulties at work/school? ☐ **Yes** ☐ **No**

Please explain:

Currently have a home: ☐ **Yes** ☐ **No**
Live alone: ☐ **Yes** ☐ **No**
Live with immediate family: ☐ **Yes** ☐ **No**
Live with extended family: ☐ **Yes** ☐ **No**
Friends: ☐ **Yes** ☐ **No**

I go to _____ for support (partner, children, family, friends, faith leader)

I use the following community resources or am involved in the community (food bank, church, St. Vincent, clubs, sports teams):

Have you/Has your child experienced a trauma (abuse, neglect, victim of natural/other disaster?
☐ **Yes** ☐ **No**

Please explain:

Please mark all that apply:

Sleep: ☐ **No Problems** ☐ **Not Enough** ☐ **Trouble Getting Up** ☐ **Nightmare/Terror** ☐ **Too Much**

Appetite: ☐ **Normal** ☐ **Increased** ☐ **Low** ☐ **Up and Down**

Interest in Sexuality (Is it age appropriate?): ☐ **Normal/Age appropriate** ☐ **Increased** ☐ **Low**

Concentration: ☐ **Normal** ☐ **Somewhat difficult** ☐ **Poor** ☐ **Terrible**

Memory: ☐ **Good** ☐ **Some difficulty remembering** ☐ **Poor**

Depressed or sad: ☐ **All the time** ☐ **Most days** ☐ **Some days** ☐ **Not at all**

Anxiety: ☐ **Panic attacks** ☐ **All the time** ☐ **Most days** ☐ **Some days** ☐ **Not at all**

Anger: ☐ **Verbal aggression** ☐ **Physical aggression** ☐ **All the time** ☐ **Most days**
☐ **Some days** ☐ **Not at all**

Suicidal thoughts (harm to self): ☐ **All the time** ☐ **Most days** ☐ **Some days** ☐ **Not at all**

Past suicide attempts: ☐ **Yes** ☐ **No**

If yes, please explain (how/when):

Homicidal thoughts (harm to others): ☐ **All the time** ☐ **Most days** ☐ **Some days** ☐ **Not at all**

Any other comments that can help me understand your concerns:

Name of person filling out form (print): _____

Relationship to Client _____

Signature Date:_____

Revised: April 14, 2025

**********To Be Completed By Therapist **********

Date of Intake: _____

Start Time: _____ End Time: _____

CPT Code: _____

Education History:

Vocational History:

Living Environment:

Social Support:

Community Resources/Community Involvement:

Risk Assessment (SI, HI, DV, unsafe environment): _____

If yes, identify the safety plan:

Patient Strengths:

Barriers:

Additional Information:

Diagnosis:

Plan:

Next Session: _____

Telehealth (Y/N): _____