Intake Form

CLIENT NAME:_____DOB:_____
LAST FIRST MI

GENDER:_____ MARITAL STATUS:_____

ADDRESS:_____

_____

HOME PHONE#_____CELL#_____

EMAIL:_____

EMPLOYER:_____

Are you currently receiving psychiatric services, professional counseling or psychotherapy elsewhere? □Yes □No

Have you had previous psychotherapy? □Yes □No

Previous therapist's name_____

Are you currently taking prescribed psychiatric medication (antidepressants or others)? □Yes □No
If Yes, please list: _____

If no, have you been previously prescribed psychiatric medication? □Yes □No
If Yes, please list: _____

HEALTH AND SOCIAL INFORMATION:

1. How is your physical health at present? (please circle one)

Poor Unsatisfactory Satisfactory Good Very good

2. Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.):

_____

_____

_____

_____

3. Are you having any problems with your sleep habits? □ Yes □ No
If yes, check where applicable:
□ Sleeping too little □ Sleeping too much □ Poor quality sleep
□ Disturbing dreams □ Other _____

4. How many times per week do you exercise? _____
Approximately how long each time? _____

5. Are you having any difficulty with appetite or eating habits? □ No □ Yes

If yes, check where applicable: □ Eating less □ Eating more □ Binging
□ Restricting
Have you experienced significant weight change in the last 2 months? □ No □ Yes

6. Do you regularly use alcohol? □ No □ Yes
In a typical month, how often do you have 4 or more drinks in a 24-hour period?
_____

7. How often do you engage recreational drug use? □ Daily □ Weekly □ Monthly
□ Rarely □ Never

8. Have you had suicidal thoughts recently? □ Frequently □ Sometimes □ Rarely
□ Never
Have you had them in the past? □ Frequently □ Sometimes □ Rarely □ Never

9. Are you currently in a romantic relationship? □ No □ Yes
If yes, how long have you been in this relationship? _____
On a scale of 1-10, how would you rate the quality of your current relationship? _____

10. In the last year, have you experienced any significant life changes or stressors:

_____

_____

_____

_____

Have you ever experienced any of the following:

Extreme depressed mood yes / no
Wild Mood Swings yes / no
Rapid Speech yes / no
Extreme Anxiety yes / no
Panic Attacks yes / no
Phobias yes / no
Sleep Disturbances yes / no
Hallucinations yes / no
Unexplained losses of time yes / no
Unexplained memory lapses yes / no
Alcohol/Substance Abuse yes / no
Frequent Body Complaints yes / no
Eating Disorder yes / no
Body Image Problems yes / no
Repetitive Thoughts (e.g., Obsessions) yes / no
Repetitive Behaviors (e.g., Frequent Checking, Hand-Washing) yes / no
Homicidal Thoughts yes / no
Suicide Attempt yes / no

OCCUPATIONAL INFORMATION:
Are you currently employed? □ No □ Yes
If yes, who is your current employer/position?

_____

If yes, are you happy at your current position?

_____

Please list any work-related stressors, if any:

_____

RELIGIOUS/SPIRITUAL INFORMATION:
Do you consider yourself to be religious? □ No □ Yes

If yes, what is your faith?

_____

If no, do you consider yourself to be spiritual? □ No □ Yes

FAMILY MENTAL HEALTH HISTORY:

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (circle any that apply and list family member, e.g., Sibling, Parent, Uncle, etc.):

Difficulty in Family Members:

Depression yes / no _____
Bipolar Disorder yes / no _____
Anxiety Disorders yes / no _____
Panic Attacks yes / no _____
Schizophrenia yes / no _____
Alcohol/Substance Abuse yes / no _____
Eating Disorders yes / no _____
Learning Disabilities yes / no _____
Trauma History yes / no _____
Suicide Attempts yes / no _____

OTHER INFORMATION:
What do you consider to be your strengths?_____

What do you like most about yourself?_____

What are effective coping strategies that you've learned?_____

_____

_____

_____

_____

What are your goals for therapy?_____

_____

_____

_____

LIMITS OF CONFIDENTIALITY:

Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. Noted exceptions are as follows:

Duty to Warn and Protect
When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the mental health professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Abuse of Children and Vulnerable Adults
If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

Insurance Providers (when applicable)
Insurance companies and other third-party payers are given information that they request regarding services to clients. Information that may be requested includes type of services, dates/times of services, and diagnosis.

I agree to the above limits of confidentiality and understand their meanings and ramifications.

_____

Client Signature (Client's Parent/Guardian if under 18) **Today's Date**

CANCELLATION POLICY:

If you fail to cancel a scheduled appointment, we cannot use this time for another client and you will be billed for the entire cost of your missed appointment.
A full fee of is charged for missed appointments or no-show cancellations with less than a 24 hour notice unless due to illness or an emergency**.** A bill will be mailed directly to all clients who do not show up for or cancel an appointment.
Thank you for your consideration regarding this important matter.

_____

Client Signature (Client's Parent/Guardian if under 18) **Today's Date**