# Initial Client Intake

*Please provide the following information for our records. Information you provide here is held to the same standards of confidentiality as our therapy.*

Legal Name: ______________________________________________________________________________
(First) (Middle Initial) (Last)

Birth Date: _____/_____/_____ Age: ____________ Nickname: _______________________________________________

Gender : ___________________ Marital Status: ____________ Number of Marriages _______ No of Children____________

Address: _________________________________________________________________________________
(Street and Number) (Apt. #) (City) (State) (Zip)

Primary Number: ___________________________ May we leave a message? _____ Yes _____ No

E-mail: _______________________________________________ May we leave a message? _____ Yes _____ No

Where should we send an appointment reminder? _______ E-mail or _______ Text message

Please indicate the primary reason for your visit today: _______________________________________________________________

## Insurance Information

**Subscriber Name** (If self )___________________________________

**Subscriber Address** __________________________________________________________________________

**Subscriber Date of Birth** _______________ **Client's relationship to Subscriber** ___________________________

**Is there secondary insurance** _____

## OCCUPATIONAL INFORMATION:

Are you currently employed? _____ Yes _____ No If yes, who is your current employer? _______________________________

Current Position? ______________________ Please list any work-related stressors: _______________________________________

Highest grade completed: __________ Are you a veteran or currently active in the U.S. Military? _____ Yes _____ No



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## MEDICAL INFORMATION:

Physician ________________________________ Phone _________________ May we contact? _____ Yes _____ No

Psychiatrist ______________________________ Phone _________________ May we contact? _____ Yes _____ No

**List any major medical problems, surgeries, hospitalizations and/or allergies.**

| **(1) (3)** |
|---|
| **(2) (4)** |

**Current Medications/Dosages Allergies:** ___________________________________________

___________________________________________________________________________

___________________________________________________________________________

_____________________________________ _____________________________________

**Mental Health Treatment History: Please list any previous psychological/psychiatric services & related information.**

| Type of Service | Dates of Service | Provider Reason for Service |
|---|---|---|
| | | |
| | | |
| | | |

## HEALTH AND SOCIAL INFORMATION:

1. How would you describe your physical health? ___ Poor ___ Unsatisfactory ___ Satisfactory ___ Good ___ Very Good
2. Current Symptom List: Please mark all that apply at present:

_____Poor Memory _____ Headaches _____ Nightmares _____Stress _____ Shyness _____ Other

_____ Impulsiveness _____ Depression _____ Sexual Dysfunction _____ Anxiety _____ Rage/Anger

_____Hallucinations _____ Guilt/Shame _____ Excitability _____ Tension _____ Racing Thoughts

_____ Worthlessness _____ Panic Attacks _____ Stomach Trouble _____ Bedwetting ____ Risky Behaviors

_____ Fatigue _____ Worry _____ Intrusive Thoughts _____ Helplessness ____ Harm to Self/Others

3. Are you having any problems with your sleep habits? _____ Yes _____ No If yes, mark where applicable: _______

Sleeping too little _______ Sleeping too much _______ Poor quality sleep

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: _____ Yes _____ No If yes, check where applicable: _______ Eating less _______ Eating more _______ Binging _______ Restricting

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6. Have you experienced significant weight change in the last two months? _____ Yes _____ No

7. Do you regularly use alcohol? _____ Yes _____ No

In a typical month, how often do you have 4 or more drinks in a 24 hour period? ____________

8. How often do you engage in recreational drug use? ______ Daily/Weekly ______ Monthly ______ Rarely ____ Never

9. Have you had suicidal thoughts recently? _______ Frequently _______ Sometimes ____ Rarely ____ Never

Have you had them in the past? _______ Frequently _______ Sometimes ____ Rarely ____ Never

10. Are you currently in a romantic relationship? _____ Yes _____ No

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? _______________________________________

11. In the last year, have you experienced any significant life changes or stressors?

_______________________________________

## Have you ever experienced the following? Please check all that apply.

Extreme depressed mood Wild Mood Swings Panic Attacks
Rapid Speech Extreme Anxiety Phobias
Sleep Disturbances Hallucinations Suicide Attempt
Unexplained losses of time Memory lapses Eating Disorder
Alcohol/Substance Abuse Chronic pain Repetitive behaviors
Body Image Problems Repetitive Thoughts Homicidal Thoughts

### FAMILY MENTAL HEALTH HISTORY:

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

**Diagnosis Family Member(s) Diagnosis Family Member(s)** Depression ___________________ Bipolar Disorder ____________________

Anxiety Disorders ___________________ Panic Attacks ____________________ Schizophrenia ___________________ Substance Abuse ____________________ Eating Disorders ___________________ Trauma History ____________________ Learning Disability ___________________ Suicide Attempts ____________________

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