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**Client Intake Form**

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| **Name of Client**      **Name of Legal Guardian (if client is a minor)** | | **Today’s Date** |
| **Client Address**        **Address of Legal Guardian if different from Client** | | **Client Date of Birth**        Age |
| **City State Zip** | **Preferred Phone Number:**    **Okay to leave Message?** Y N  **Okay to text?**  Y N | **Client Marital Status**: *(circle)*  Single  Married  Divorced  Widowed  Separated |
| **Email Address?**  **Okay to use for communication with you?** | **Alternate Phone**: Cell Home  Work    **Okay to leave Message**? Y N  **Okay to text?** Y N | **If Client is a Minor:**  **Parent’s Marital Status:** (circle)    Single  Married  Divorced  Widowed  Separated |
| **What brought you to counseling today?** | |  |
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| **Referral Information** | | | | | | | |
| How did you hear about this practice (who referred you)? | | | | | | | |
| Are you currently involved with a pending or active legal suit (Probation, CPS, etc.)? YES NO If YES, who?  If YES, please complete the Legal and Court Status Information Form Attached | | | | | | | |
| Are you currently seeking counseling services elsewhere? YES NO | | | | | | | |
| **Employment Information** | | | | | | | |
| Employer (if unemployed, list most recent employer, If Student, provide school name & grade) | | | | | | | |
| Employment Status: Student Unemployed Full-Time Part-Time  Volunteer Retired | | | | | | | |
| **Family** | | | | | | | |
| **Name** | | **Relation** | **Age** | **Living (Y/N)** | **In**  **Home?**  **(Y/N)** | **Brief description of any mental or substance use history?** | |
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| **Please circle the symptoms you have experienced in the last month** | | | | | | | |
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|  | Crying spells  Unable to have fun  Feelings easily hurt  Lacking in confidence  Constipation  Feeling grouchy  Always tired  Poor appetite  Depressed  Trouble sleeping | Fast heartbeat  Always worried  Frequent sweating  Dizziness  Shaky hands  Stomach trouble  Nightmares  Feeling tense  Cold feet and hands  Feeling panicky | | | | | Money problems  Relationship concerns  Work difficulties  Sexual problems  Can’t hold a job  Excessive drinking  Excessive medication use  Excessive drug use  Problems with children  Problems with parents | |  |

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|  | Feeling lonely  Loss of weight  Not enjoying things  Suicidal thoughts  Loss of sexual interest  No one understands me  Worried about health  Can’t concentrate  Can’t “get going”  Feeling angry  Don’t like being alone  Lack of energy | | | Diarrhea  Shy with people  Muscle twitching  Nausea or vomiting  Can’t make decisions  Can’t make friends  Headaches  Fainting spells  Unable to relax  Feeling fearful  Overly sensitive  Anxious inside  Weight gain | | | | | Poor physical health  Fighting and quarreling  Dislike my body  Full of energy  Overly ambitious  Easily excited  Quick tempered impatient  with people Binge eating  Very restless  Feel like hurting someone  Feel like smashing things  Excessive overeating Thoughts of hurting myself Other: | | |  |
| **Medical Information** | | | | | | | | | | | | |
| **Overall Physical health** | | **Excellent Very Good Good Fair**  **Poor Bad** | | | | | | | | | | |
| **Date of Last**  **Physical** | |  | | | **Currently being seen by a medical doctor?** | | | | | | **YES NO** | |
| **Have you ever experienced a head injury, concussion or loss of consciousness?** | | | | |  | | **If YES, how many times?** | | | |  | |
| **List your current medical prescriptions including vitamins, supplements & hormone therapies**  ***Please inform your counselor if this list changes over time. Use the back of this page as needed*** | | | | | | | | | | | | |
| **Name** | | | **Reason** | | | | | | | **Dosage/Day** | | |
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| **Have you taken any anti-depressant or anxiety drugs in the past? YES NO** | | | | | | | | | | | | |
| **Have you ever been hospitalized for mental health or substance related issues? YES NO**  **If YES, please provide the following** | | | | | | | | | | | | |
| **Place** | | | **Reason** | | | **Dates** | | **Discharge Status**  *(ex: left against medical advice, completed program, ran out of insurance)* | | | | |
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**I have made every effort possible to provide the most current and accurate information on this form and understand I am responsible for informing my counselor of any updates.**

**Client**

**Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date\_\_\_\_\_\_\_\_\_**