Grace Counseling & Consulting

Dr. Jim Seward EdD, LMHC

Intake Form

Please provide the following information and answer the questions below. Please note information you provide here is protected as confidential information. Please fill out this form and bring it to your first session.

Patient Information:

Patient Name:___________________________________(Last) (First) (Middle Initial)

*If under 18 years old - Name of parent/ guardian of patient:____(Last) (First) (Middle Initial)

Patient Social Security # __ __ __ - __ __ - __ __ __ __ Birth Date: __ __ / __ __ / __ __ Age: _____

Address: ____Street City State Zip

Mailing address if different from above:

____

Home Phone: ( ) - May I contact you or leave a message? ☐ Yes ☐ No

Cell/Other Phone: ( ) - May I contact you or leave a message? ☐ Yes ☐ No

E-Mail: ____________________________________ May I email you? ☐ Yes ☐ No

** Please note: Email correspondence is not considered to be a confidential medium of communication.

If no contact is requested, please explain: ____

I was referred by: ____

How did you hear about us? ____

Emergency Contact for patient:______________________(____)________________ (First and last name Relationship Phone Number)

Insurance Information:

Policy Holder Name: _____________________ Birth date: ______________________

Address (if different from client) ____

Medical Insurance Company __________________________________
Employer____________________________

EAP/Mental Health Company (if different from above) _________________________________

Insurance ID number or Social Security Number (if EAP or Private Pay): ____________________

Relationship to Client __________________________

Is there secondary Insurance?

____

Please complete if client is a minor:

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Father's Name ______________________ Social Security Number _____________________

Father's Address _______________________ Phone Number ____________________________

Employer _______________ Date of Birth _____________ Work Phone _________________________

Mother's Name _______________________ Social Security Number ____________________

Mother's Address ______________________ Phone Number ___________________________

Employer _______________ Date of Birth _____________ Work Phone _________________________

List name and phone number of Primary Care Physician (PCP): ________________________________

PRESENTING PROBLEM:

I am seeking help for (please check all that apply):

- o Abuse
- o Anxiety
- o Anger
- o Alcohol problem
- o Aggression
- o Depression
- o Domestic violence
- o Emotional control
- o Substance use
- o Trauma
- o Career Issues
- o Legal problems
- o Relationship problems
- o School problems
- o Not sure
- o Other

Brief description:
____

Impact on functioning: -
____

BACKGROUND INFORMATION

IDENTIFICATION:

Currently: ☐Never Married ☐Domestic Partnership ☐Married ☐Separated ☐Divorced ☐Widowed

If applicable, how long have you been in your current relationship? _____ Months _____ Years

On a scale of 1 – 10, circle satisfaction with current relationship:

(low satisfaction) 0 1 2 3 4 5 6 7 8 9 10 (high satisfaction)

Please give name, age, and sex for each of your children: ☐ No children

Name of each child:

Age:

Sex:

Biological:

Stepchild:

Custody status:

Race/Ethnicity: ___________________________________ □ I choose not to answer

Do you believe anything in your cultural background would create a barrier to treatment? □ Yes □ No

Brief description:
____

Do you consider yourself to be spiritual or religious? □No □Yes, Religion/Belief:
____

Gender: □ Male □ Female □Androgynous □Gender neutral □Transgender □Other □Prefer not to answer

HISTORY OF PRESENTING PROBLEM:

What significant life changes or stressful events have you experienced recently:
____

____
____
____

Patient's current symptoms.

Please check □ all that apply:

Mild = Impacts quality of life, but no significant impairment of day-to-day functioning
Moderate = Significant impact on quality of life and/or day-to-day functioning
Severe = Profound impact on quality of life and/or day-to-day functioning

*Symptoms unchecked will be considered not applicable.

Aggressive behaviors Laxative/diuretic abuse

Agitation/Irritability Lightheaded

Anger Loss of touch with reality

Anorexia Low esteem

Anxiety (generalized) Mood swings

Appetite disturbance Muscle tension

Bingeing/purging Nausea

Circumstantial symptoms Nightmares

Conduct problems Obsessions/Compulsions

Delusions Oppositional behavior

Depressed mood Overly talkative

Perception/sensations of world seems unreal Panic attacks

Difficulty making decisions Paranoid thinking

Dizziness Phobias (fears)

Elevated mood (Mania) Poor hygiene

Elimination (toileting) disturbance Psychomotor retardation

Emotionality Related medical conditions

Fatigue/low energy Restlessness

Feeling of choking Seeking excessive pleasure

Flashbacks Self-mutilation

Racing/Rapid thoughts Sexual dysfunction

Forgetfulness Significant Light gain/loss

Grief Sleep disturbance

Guilt Social isolation

Hallucinations Somatic complaints

Hopelessness Tremble or shake

Hyperactivity Trouble concentrating/Distractibility

Impulsiveness Trouble with daily living activities

Intrusive thoughts Worthlessness

Invincibility

PAST PSYCHIATRIC HISTORY:

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

□No □Yes, name of your Psychiatrist/Psychologist? ____

FAMILY HISTORY:

Describe your childhood family experience:

□ Outstanding home environment □ Normal home environment □ Chaotic home environment

□ Witnessed physical/verbal/sexual abuse toward others □ Experienced physical/verbal/sexual abuse from others

People in your family who Ire important as you grew up: ____________________________________

Father: □ Living □ Deceased How do you get along?: _________________________________

Mother: □ Living □ Deceased How do you get along?: _________________________________

Siblings and how do you get long:____

FAMILY PSYCHIATRIC HISTORY:

Mental health history.

Please check all that apply:

Self (Patient)

Mother

Father

Siblings

Maternal

Grandparents

Paternal

Grandparents

Maternal

Aunts/Uncles

Paternal

Aunts/Uncles

Alcohol/Substance Abuse

Anxiety

Behavioral Problems

Dementia

Depression

Domestic Violence

Eating Disorder

Emotional Problems

Gambling Addictions

Mental Retardation

Obsessive Compulsive Disorder (OCD)

Schizophrenia

Suicide Attempts

Other Mental Illness

MEDICAL CONDITIONS & HISTORY:

How would you rate your current physical health? GOOD FAIR POOR

Medical History: In the section below, identify if there is a history of any of the following:

If other*, please provide any important information or history:____________________________

____

____

Please describe any significant illnesses, hospitalizations, or accidents you have had:____

____

Please list any specific health problems you are currently experiencing:

____

____

____

Medical health history.

Please check all that apply:

Allergic reaction

Alzheimer's

Birth defects

Cancer

Diabetes

Heart disease

High blood pressure

Obesity

Stroke

Thyroid problems

Tobacco use

Tuberculosis

Chronic pain

Other* chronic or serious health issue

CURRENT MEDICATION:

Please provide a current list/copy of all medications or complete the following:

Have you ever been prescribed psychiatric medication? ☐No ☐Yes if yes, please list information:

Medication Dosage Frequency Reason Prescribing Doctor

Are you currently taking any prescription medication? ☐No ☐Yes if yes, please list information:

Medication Dosage Frequency Reason Prescribing Doctor

SUBSTANCE USE:

How often do you engage in recreational (illicit/non-prescribed) drug use?

☐ Never ☐ Infrequently ☐ Monthly ☐ Weekly ☐ Daily

SOCIAL HISTORY:

My social support system is:

☐ a supportive network ☐ few or no friends ☐ substance abuse friends ☐ distant from family of origin

GCC

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Making a lasting difference in the lives of others.

My living/housing situation is:

□ Adequate □ Overcrowded □ Homeless □ Dependent on others □ Dangerous/deteriorating □ Living companion(s) are dysfunctional

My financial situation includes:

□ No problems □ Large indebtedness □ Poverty or below-poverty income □ Impulsive spending □ Relationship conflicts over finances

Sexual orientation?

□ Bisexual □ Gay □ Lesbian □ Straight/Heterosexual □Other □Prefer not to ansIr

Are you currently sexually active?

□ Yes □ No □ I use protection/birth control Sexually □ Satisfied □ Dissatisfied

EDUCATIONAL/OCCUPATIONAL HISTORY:

Current Employment: □ Full-time □ Part-time □ Unemployed □ Volunteer work □ Homemaker □ Student

Current or highest education level completed: K 1 2 3 4 5 6 7 8 9 10 11 12 □ GED

□ Some college □ College degree completed: ________________________ □ Other: ______________

Current School or College (if Applicable):____

Grades achieved Ire: □ GOOD □ FAIR □ POOR

Name of Employer (if applicable) ____

On a scale of 1 – 10, circle current job satisfaction: (low satisfaction) 0 1 2 3 4 5 6 7 8 9 10 (high satisfaction)

Describe the work you do:

____

Length of employment: ____

Relationship with co-workers(s): □ GOOD □ FAIR □ POOR

Relationship with Supervisor(s): □ GOOD □ FAIR □ POOR

Do you enjoy your work? Is there anything stressful about your current work?

____

□ Served in military □ no-incident □ with incident Branch _____________________________

LEGAL HISTORY:

Have you ever been arrested? □ No □ Yes – if yes, please provide details:

☐ Arrest(s) NOT substance related, how many times? ________ ☐ Non-violent offense ☐ Violent offense

☐ Arrest(s) substance related, how many times? ________

☐ I am currently on probation/parole

☐ I am currently in drug court

☐ My charge was related to a domestic violence offense

☐ I have served time in jail/prison. Total time served? __________

STRENGTHS:

What do you consider your strengths?

____

LIMITATIONS:

What do you consider your Limitations?

____

What would you like to accomplish or set as a goal(s) to achieve in therapy?

____

____