**CLIENT INTAKE INFORMATION**

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_\_\_\_\_\_\_\_\_\_ Age \_\_\_\_\_

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Preferred Pronouns\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City/State/Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home/Cell #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In an emergency, who may I contact? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INSURANCE:**

**Primary Insurance Company**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group # \_\_\_\_\_\_\_\_\_\_\_\_

Subscriber Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client’s relationship to insured (Circle): Self / Spouse or Partner / Child / Other

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address and Phone (if different from client):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Secondary Insurance Company**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group # \_\_\_\_\_\_\_\_\_\_\_\_

Subscriber Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client’s relationship to insured (Circle): Self / Spouse or Partner / Child / Other

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address and Phone (if different from client):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please sign below to show you understand and agree there may be limits to your insurance coverage. Your signature authorizes my office to bill your insurance for services, to disclose requested information to your insurance company, and for your insurance to reimburse me for those services. Should there be limits to your insurance coverage, or there be costs and/or fees incurred in connection with collection of my account, you will pay all such costs and fees and that **you are ultimately responsible that your account be paid in full.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date

***Please take your time to respond with as much honesty and completeness as possible, or indicate if***

***You would rather discuss a question in person.***

***Your responses will facilitate our work together. Thank you for your time.***

How did you hear about my practice? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How do you spend your days: Employer / School\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation / Studying\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long have you been doing this work or at this job: \_\_\_\_\_\_\_\_\_\_ and/or what grade/year in school: \_\_\_\_\_\_\_\_\_\_\_

What is the highest grade completed: \_\_\_\_\_\_\_\_ If you have a degree, what is it and from where: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If unemployed or disabled, how long have you been in this situation? \_\_\_\_\_\_\_\_\_\_\_\_ Please describe:

If you’re considering a change in job or career, what type of work are you interested in pursuing:

Have you ever served in the military? \_\_\_\_ If yes, list branch, rank and current status (active/discharged/retired):

Any past or pending legal issues? \_\_\_\_\_ If yes, please describe:

**MEDICAL INFORMATION:**

On a scale of 1-5 (1 failing, 2 poor, 3 average, 4 good, 5 excellent)

How would you rate your current physical health: \_\_\_\_\_ mental health: \_\_\_\_\_\_ spiritual health:\_\_\_\_\_\_\_\_

Please list any major medical conditions, operations, illnesses or injuries that currently affect your life:

**Current Medications: Dosage Frequency For What Symptom? Prescribing Dr.**

Primary care physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date last seen: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ FAX:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Specialist physician / issue:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date last seen: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ FAX:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any other current treatment providers important in your healthcare:

Do you currently exercise: \_\_\_\_\_\_ If yes, please describe activity, duration, frequency:

Do you use any recreational drugs or pills (sleeping, diet, etc.) Yes / No If yes, how many days/wk.?

If yes, which drugs and how much do you use? What time of day?

Do you consume alcohol or use marijuana? (circle which) If yes, how many days per week \_\_\_\_ What time of day \_\_\_

How many units of alcohol? (e.g. 1 bottle beer, 1 glass/wine, 1.5 oz. hard liquor)

How much marijuana and what form?

Have you ever believed your substance use was a problem for you: \_\_\_\_ if yes, describe:

Has anyone ever told you they believed your substance use was a problem: \_\_\_\_\_ if yes, date:\_\_\_\_\_

Have you ever had withdrawal symptoms when trying to stop using any substances:\_\_\_ if yes, date: \_\_\_\_\_

Have you ever had problems with work, relationships, health, the law, etc. due to your substance use? \_\_\_\_\_

If yes, please describe:

Do you currently or have you ever attended AA, NA or ACOA groups:\_\_\_

If yes, please list length of time sober and number of meetings you attend per week:

Have you ever been in a drug or alcohol treatment program: Yes / No

 If yes, (Circle) Inpatient Outpatient

 *Where When How Long Outcome*

Do you currently or have you ever had trouble sleeping: \_\_\_\_\_\_ If yes, please describe and how you’re addressing it:

Do you currently or have you ever had challenges with eating, your weight or with food:\_\_\_\_\_\_ If yes, please describe:

**MENTAL HEALTH INFORMATION:**

Have you ever received therapy or counseling before? (Circle) Yes / No

If yes, please give:

*Dates/location Type of therapist Purpose Reason for Termination*

Feel free to describe what was most helpful or unhelpful in your previous experience:

Are you currently receiving other mental health services: \_\_\_\_\_ If yes, please list practitioner(s) and type of services:

What prompted you to initiate counseling now?

What are your expectations or hopes for our work together?

If you have any concerns regarding therapy, please describe:

How will you know you're done with therapy?

Have you received a mental health diagnosis before? If yes, please list diagnosis/es and date(s) first diagnosed:

Have you taken psychotropic medication(s) in the past? If yes, please describe:

*Dates? Medication? to treat what? Result? Prescribing Physician*

Have you ever been hospitalized for psychological or emotional issues? (Circle) Yes / No

 *When Where Reason Outcome*

Have you currently, recently, or in the past, had suicidal or homicidal thoughts and/or attempts?

If yes, please circle which, indicate when and describe.

**RELATIONSHIP INFORMATION**

Current relationship status: Length of current status: Sexual orientation:

Partner's first name: How long have you known each other: How long have you been a couple:

If you are currently experiencing relationship difficulties, how long have they been present?

What is the most challenging dynamic for you to manage / handle at this time?

What do you hope to improve in your intimate relationship?

Previous significant relationships/partnerships/marriages/separations/divorces/death of partner and years together:

If you have any children, please give their names, ages, location and give a word or two to describe your relationship:

**FAMILY INFORMATION:**

With whom did you live growing up / who raised you?

Who or what did you turn to for comfort as a child?

Mother’s current age and location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ If deceased, her age at death:\_\_\_\_\_

 Cause of death? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Your age at time of death: \_\_\_\_\_

Give one word or a phrase to describe your relationship with her:

Father’s current age and location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ If deceased, his age at death:\_\_\_\_\_

 Cause of death? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Your age at time of death:\_\_\_\_\_

Give one word or a phrase to describe your relationship with him:

Did your parents divorce:\_\_\_\_ If yes, what was your age at time of separation: \_\_\_\_ divorce: \_\_\_\_\_\_

If your parents remarried, which parent(s) remarried and what was your age at time of remarriage?

Please list the names of your siblings, their age, where they live, give a word/phrase to describe your relationship,

and circle the family member(s) with whom you feel closest:

**SPIRITUAL INFORMATION:**

Have you ever or do you currently engage in a personal faith practice? \_\_\_\_ If yes, please describe:

Have you ever, or do you currently belong to a faith community: \_\_\_\_\_

If yes, please describe your current level of connection and involvement:

Would you like to incorporate your faith/spirituality into therapy: \_\_\_\_

If yes, please describe how that would look to you:

How does the future look to you:

What do you wish for the future:

What or who helps sustain you during difficult times?

Hobbies and sources of self care:

Anything else you want to be sure I know?

**FAMILY HISTORY QUESTIONNAIRE (personal history is asked following this page)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Please indicate if there is a family** **history of any of the following:** | Past | Present | Which family member(s)?  |  Briefly describe if you wish: |
| Addictions: |  |  |  |  |
| Alcoholism |  |  |  |  |
| Drug Dependency/Abuse |  |  |  |  |
| Gambling |  |  |  |  |
| Internet |  |  |  |  |
| Pornography |  |  |  |  |
| Sex  |  |  |  |  |
| Food |  |  |  |  |
| Other addictions/specify: |  |  |  |  |
| Affairs/Infidelity/secrets |  |  |  |  |
| Abandonment |  |  |  |  |
| Suicide |  |  |  |  |
| Mental Illness |  |  |  |  |
| Depression |  |  |  |  |
| Anxiety Disorders |  |  |  |  |
| PTSD |  |  |  |  |
| Traumatic Event (specify) |  |  |  |  |
| Personality Disorder |  |  |  |  |
| Psychiatric Care |  |  |  |  |
| Disordered Eating (Over, Under, Binge, Purge) |  |  |  |  |
| Abuse, Trauma, Violence: |  |  |  |  |
|  -Physical |  |  |  |  |
|  -Emotional/Verbal |  |  |  |  |
|  -Sexual |  |  |  |  |
|  -Domestic |  |  |  |  |
|  -Child |  |  |  |  |
|  -Other |  |  |  |  |
| Gender Identity / Transition |  |  |  |  |
| Sexual Orientation  |  |  |  |  |
| Military Service |  |  |  |  |
| War Veteran |  |  |  |  |
| Unsafe Living Situation |  |  |  |  |
| Chronic Illness |  |  |  |  |
| Medical Crisis or serious injury |  |  |  |  |
| Infertility |  |  |  |  |
| Miscarriages |  |  |  |  |
| Abortions |  |  |  |  |
| Adoption |  |  |  |  |
| Physical or Speech Disability |  |  |  |  |
| Religious persecution |  |  |  |  |
| Financial Pblms./Bankruptcy |  |  |  |  |
| Criminal behavior |  |  |  |  |
| Shoplifting |  |  |  |  |
| Unemployment |  |  |  |  |
| Homelessness |  |  |  |  |
| Incarceration |  |  |  |  |

 **PERSONAL HISTORY**

|  |  |  |  |
| --- | --- | --- | --- |
| **Please check any areas which** **affect(ed) you:** | **Past**year(s)? | **Present** |  **Briefly describe if you wish:** |
| Anxiety |  |  |  |
| Panic Attacks |  |  |  |
| Phobias |  |  |  |
| Depressed mood |  |  |  |
| Loss of interest/pleasure |  |  |  |
| Moodiness |  |  |  |
| Crying spells |  |  |  |
| Fatigue/Lethargy |  |  |  |
| Feelings of worthlessness |  |  |  |
| Shame/guilt |  |  |  |
| Hopelessness |  |  |  |
| Loss/Grief |  |  |  |
| Body Image  |  |  |  |
| Excessive worry/fear |  |  |  |
| Lying/Deceitfulness |  |  |  |
| Attention/concentration problems |  |  |  |
| Memory problems |  |  |  |
| Restlessness/hyperactivity |  |  |  |
| OCD behavior/tendencies |  |  |  |
| Traumatic event |  |  |  |
| PTSD |  |  |  |
| Insomnia / Sleep disturbances |  |  |  |
| Nightmares |  |  |  |
| Loneliness |  |  |  |
| Alcoholism |  |  |  |
| Drug Dependency/Abuse |  |  |  |
| Gambling |  |  |  |
| Pornography |  |  |  |
| Sex  |  |  |  |
| Food  |  |  |  |
| Internet  |  |  |  |
| Phone |  |  |  |
| Other addictions: (which?) |  |  |  |
| Weight loss / gain (circle) |  |  |  |
| Increased / decreased appetite (circle) |  |  |  |
| Disordered Eating (circle) Over, Restricted, Binge, Purge |  |  |  |
| Relationship/Marital problems |  |  |  |
| Unusual parenting challenges |  |  |  |
| Divorce / Separation |  |  |  |
| Affairs/Infidelity |  |  |  |
| Lying |  |  |  |
| Problems w/ sexual functioning |  |  |  |
| Increase/decrease in sexual desire (circle) |  |  |  |
| Suicidal Thoughts / attempts |  |  |  |
| Self injury |  |  |  |
| Harm to others |  |  |  |
| Violence |  |  |  |

**PERSONAL HISTORY**

|  |  |  |  |
| --- | --- | --- | --- |
| **Please check any areas which** **affect(ed) you:** | **Past.** **(year?)** | **Present** | **Briefly describe if you wish:** |
| Criminal activity |  |  |  |
| Victim of a crime |  |  |  |
| Anti-social behavior |  |  |  |
| Incarceration |  |  |  |
| Discrimination |  |  |  |
| Sexual Orientation |  |  |  |
| Gender Identity / Transition |  |  |  |
| Abuse, Trauma, Violence: |  |  |  |
|  -Physical |  |  |  |
|  -Emotional/Verbal |  |  |  |
|  -Sexual |  |  |  |
|  -Domestic |  |  |  |
|  -Child |  |  |  |
| Unsafe Living Situation |  |  |  |
| Abandonment |  |  |  |
| Death of close friend or family member  |  |  |  |
| Death of a close friend during childhood |  |  |  |
| Infertility |  |  |  |
| Loss or death of a child |  |  |  |
| Miscarriages |  |  |  |
| Unplanned pregnancy(ies) |  |  |  |
| Abortion(s) |  |  |  |
| Medical Crisis |  |  |  |
| Chronic Illness or Injury |  |  |  |
| Disability (describe) |  |  |  |
| Hate Crime |  |  |  |
| Cult Participation |  |  |  |
| Religious persecution |  |  |  |
| Financial Problems or Bankruptcy |  |  |  |
| Problems in the workplace |  |  |  |
| Problems at school |  |  |  |
| Job change or uncertainty |  |  |  |
| Shoplifting |  |  |  |
| Unemployment |  |  |  |
| Homelessness |  |  |  |
| Frequent/Multiple moves |  |  |  |
| Military service |  |  |  |
| War Veteran |  |  |  |
| Other: |  |  |  |

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Client signature) (Date)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Print name)