CLIENT INTAKE

Client: _____ Birthdate: _____/_____/_____

Complete Address: _____
Phone #: _____Email: _____
Please indicate the means by which you prefer to be contacted. You may check more than one: Phone: _____ Text: _____ Email: _____

Relationship Status:
☐ Single ☐ Committed/Married ☐ Separated ☐ Divorced ☐ Widowed
Significant Other's name_____
Children's names/ages: _____

If client is a minor, please have ***each*** parent/guardian with legal custody sign the ***Consent to Treat a Minor form.***
Parent/Legal Guardian(s): _____
Address(s) (if different): _____
Best phone number to be reached: _____
Child lives with: _____
Person(s) responsible for payment of services: _____

While I am not contracted with any insurance companies, some plans do reimburse a portion of my fee directly to clients. I suggest you contact your insurance company and ask what coverage you may have when using an out-of-network provider.

Will insurance be billed for services? ☐ Yes ☐ No Will you need a monthly invoice? ☐Yes ☐ No May I email you your invoices? ☐Yes ☐No

Have you ever sought/received psychiatric or psychological treatment of any kind? ☐YES ☐NO
Please circle type of ***previous*** therapy:
Child Individual Couple Family Group Inpatient Medication

When and how long were you in therapy? _____
Are you currently under the care of a Psychiatrist or other mental health service provider?
☐ Yes ☐ No
If so, please provide contact information and sign a ***Consent to Release Information*** form so that I may contact him/her to consult on services provided.

If you are currently taking any prescription medications, please list the type of medication, the dosage, the reason for the prescription, and any side effects that you are experiencing.
_____
_____
_____

I understand that the following questions are very personal in nature. They are meant to help provide a general overview of possible areas to be discussed. Your reason for coming to therapy may or may not be included. Please remember that you will have time to speak in more detail. If you do not feel comfortable answering any of these questions at this time please feel free to leave the response blank.

Do you have a history of depression? ☐ YES ☐ NO History of anxiety? ☐ YES ☐ NO

Suicidal thoughts or attempts? ☐ YES ☐ NO Hospitalizations? ☐YES ☐ NO
Are you currently considering harming yourself or others? ☐YES ☐NO
Is there any direct or indirect family history of mental illness? ☐YES ☐ NO
Please describe: _____

Have you ever been emotionally, physically or sexually abused?
☐ YES ☐ NO ☐ Uncertain ☐ Prefer not to answer.
Are you currently being emotionally, physically or sexually abused?
☐ YES ☐ NO ☐ Uncertain ☐ Prefer not to answer.

Have you ever been treated for alcohol or drug dependence? ☐YES ☐NO
If so, when and where? _____
Did you complete the treatment program? ☐ YES ☐ NO

Please circle any of the following areas where you have concern:

Physical Health Anxiety/Nervous Mood Instability Depression
Eating Habits Sleeping Habits Ability to control anger Suicidal Thoughts Alcohol/Drug use Self-harm behaviors Paranoid thoughts Social struggles
Infidelity Communication/Relationship Loss/Death Personal Stress Employment
Caring for an elder or dependent Phase of Life Separation/Divorce
Abusive Behavior (emotional, physical, sexual) Parenting/Co-Parenting
Family relationships Major life decision Professional Stress

Please briefly describe your reason(s) for seeking therapy at this time. Describe current concerns, issues, or problems you hope to resolve.

_____
_____
_____
_____
_____

Please describe any specific goals you have for therapy.

_____
_____
_____