

INTAKE FORM

CLIENT INFO

Name _____ Date _____

Address _____

Occupation _____ Employer _____

Date of Birth _____ Age _____ Gender _____

Phone _____ Email _____

Emergency contact name _____ Relationship _____

Emergency contact phone _____

Who referred you to us or how did you hear about us? _____

Religious/spiritual history: _____

Number, age, and gender of children _____

Marital/relationship history _____

Level of education _____

HEALTH & WELLNESS BACKGROUND

Primary Care Physician _____

Psychiatrist _____

Do you have any significant physical or mental health diagnoses? If so, what? _____

Are you taking any medications? _____

Are you taking any supplements (including CBD)? _____

How do you grade your:

Physical health?

excellent good fair poor getting worse getting better

Emotional/Mental health?

excellent good fair poor getting worse getting better

Mental health treatment history (please include previous treatment history and diagnoses):

History of Hospitalizations? _____

Family history of mental health or emotional challenges _____

Number of siblings, including yourself _____ Your birth order _____

Other significant family information _____

What role do animals play in your life? _____

Have you experienced domestic violence?

physical sexual financial threats intimidation emotional isolation

Is there anything else you wish to tell me that you feel relates to your visit? _____

What brings you in to psychotherapy? _____

How long have you had the problem(s)? _____

What other ways have you tried to deal with this problem? _____

If you have a history of any of the following symptoms, please mark them "HX." If you are experiencing any of these presently, please label them, "PR."

_____ High Blood Pressure

_____ Low Blood Pressure

_____ Dizziness or fainting

_____ Ulcers

_____ Indigestion

_____ Irritable Bowel (IBS)

_____ Pounding/Racing Heart

_____ Chest pain

_____ Shortness of breath

_____ Fearfulness

_____ Anxiety

_____ Panic attacks

_____ Nightmares

_____ Vivid dreams

_____ Difficulty sleeping

_____ Migraine headaches

_____ Tension headaches

_____ Changes in appetite

_____ Weight gain/loss

_____ Fatigue/low energy

_____ Prolonged sadness

_____ Depression

_____ Guilt

_____ Feelings of inadequacy

_____ Heavy drinking

_____ Drug use or abuse

_____ Diabetes

_____ Hypoglycemia

_____ Hypothyroidism

_____ Colitis

_____ Suicidal thoughts

_____ Suicide attempt(s)

_____ Unstable job pattern

_____ Job unhappiness

_____ Lack sense of meaning

_____ Lack sense of purpose

Please check the items you would like to address in therapy:

Symptom-Related Concerns

- Anxiety
- Depression
- Unhappy
- Lack of confidence
- Grief/loss
- Anger
- Numbness
- Develop coping skills

Health Concerns

- Medical/Physical illness
- Difficulty sleeping
- Nightmares
- Exhaustion
- Drug-related concerns
- Alcohol-related concerns
- Eating or weight-related

Personal Goals

- Develop clearer sense of identity
- Concerns related to spirituality
- Deepen inner work
- Dreamwork
- Meaning & purpose
- Develop self-awareness
- Develop assertiveness

Social Relationships

- Social anxiety
- Shy around others
- Difficulty making friends
- Isolation/Loneliness
- Difficulty relating
- Conflict with others

Career/work

- Career choice
- Financial concerns
- Difficulties at work
- Problems making decisions
- Personality conflicts
- Overwork/stress
- Life/Work balance

Spouse/Significant Other

- Marital Concerns
- Difficulty relating
- Conflict
- Verbal abuse
- Physical abuse
- Sexual concerns
- Financial stress

What are your goals for therapy? _____

CONSENT FOR TREATMENT

Your signature below indicates that you consent to the provision of psychological or mental health services for yourself and/or dependent named below. It also serves as an acknowledgment that you have received or been apprised of how to secure the HIPAA notice form.

Client Name

Signature (Parent/Guardian if patient is a minor)

Date

Relationship to Client

CONSENT FOR CONTACT

Your signature below indicates that you consent to our team members contacting you to conduct business related to therapy, including scheduling or other issues that may arise.

Methods of Contact

- Cell phone/text messaging
- Email
- Home phone

Signature & Date

(Parent/Guardian if patient is a minor)

FINANCIAL COMMITMENT

The following guidelines have been established for payment of financial obligations for services rendered in this office. All clients are self-pay clients, meaning that no insurance is accepted. Before or during the first session, the therapist and client will set an agreed upon rate.

PLEASE BE AWARE THAT SESSIONS MUST BE CANCELLED AT LEAST 24-HOURS IN ADVANCE. THE NORMAL, AGREED UPON FEE WILL BE CHARGED FOR NO-SHOWS AND LATE CANCELLATIONS. However, exceptions will be made for adverse road conditions or other unforeseeable emergencies. If you are sick and there is a chance you may not make your session, please give your therapist as much warning as possible.

Signature & Date
(Parent/Guardian if patient is a minor)
