IHS Psychotherapy and Counseling LLC

CLIENT INTAKE FORM

Please provide the following information for our records. Leave blank any question you would rather not answer. Information you provide here is held to the same standards of confidentiality as our therapy.

Name: _____

Birth Date: _____ /_____ /_____ Age: _____ Gender: Male _____Female_____

Emergency Contact Name:
_____Relationship:_____

Emergency Contact Phone
Number(s):_____Email:_____

Marital Status:

Never Married____ Partnered____ Married_____ Separated____ Divorced_____

Widowed_____

Number of Children: _____

How did you find us? _____

Are you currently receiving psychiatric services, professional counseling or psychotherapy elsewhere? Yes._____ No_____ If yes, professional name and contact information:

Have you had previous psychotherapy?

No____ Yes____, at previous therapist's name _____

Are you currently taking prescribed psychiatric medication (antidepressants or others)?
Y____N____

Yes, please list: _____

_____

_____

If no, have you been previously prescribed psychiatric medication? Y____N____

If Yes, please list:

_____

_____

_____

HEALTH AND SOCIAL INFORMATION

1. How is your physical health at present? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

2. Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.):

3. Are you having any problems with your sleep habits? Y_____N____ If yes, check where applicable:

Sleeping too little_____

Sleeping too much_____

Poor quality sleep_____

Disturbing dreams_____

Other _____

4. How many times per week do you exercise? _____

Approximately how long each time? _____

5. Are you having any difficulty with appetite or eating habits? Y_____N_____

If yes, check where applicable:

Eating less____ Eating more_____ Binging_____ Restricting_____

Have you experienced significant weight change in the last 2 months? Y_____N_____

If yes, please explain:

6. Do you regularly use alcohol?

Frequently_____ Sometimes_____ Rarely_____ Never_____

In a typical month, how often do you have 4 or more drinks in a 24-hour period? _____

7. How often do you engage in recreational drug use?

Daily_____ Weekly_____ Monthly_____ Rarely_____ Never _____

8. Have you had suicidal thoughts recently?

Frequently_____ Sometimes_____ Rarely_____ Never_____

Have you had them in the past?

Frequently_____ Sometimes_____ Rarely_____ Never_____

9. Are you currently in a romantic relationship? Y_____N_____

If yes, how long have you been in this relationship? _____

On a scale of 1-10, how would you rate the quality of your current relationship? _____

1. Poor to 10- Fully Satisfying

10. In the last year, have you experienced any significant life changes or stressors?

11. Have you ever experienced:

Extreme depressed mood: Y_____N_____

Wild Mood Swings: Y_____N_____

Extreme Anxiety: Y_____N_____

Panic Attacks: Y_____N_____

Phobias: Y_____N_____

Sleep Disturbances: Y_____N_____

Hallucinations: Y_____N_____

Unexplained losses of time: Y_____N_____

Unexplained memory lapses: Y_____N_____

Alcohol/Substance Abuse: Y_____N_____

Frequent Body Complaints: Y_____N_____

Eating Disorder: Y_____N_____

Body Image Problems: Y_____N_____

Repetitive Thoughts (e.g., Obsessions): Y_____N_____

Repetitive Behaviors (e.g., Frequent Checking, Hand-Washing): Y_____N_____

Homicidal Thoughts: Y_____N_____

Suicide Thoughts: Y_____N_____

Suicide Attempts: Y_____N_____

OCCUPATIONAL INFORMATION:

Are you currently employed? Y_____N_____

If yes, who is your current employer/position? _____

If yes, are you happy at your current position? _____

Please list any work-related stressors, if any: _____

Are you a student?_____ full time _____part time

RELIGIOUS/SPIRITUAL INFORMATION:

Do you consider yourself to be religious? Y_____N_____

If yes, what is your faith? _____

If no, do you consider yourself to be spiritual? Y_____N_____

FAMILY MENTAL HEALTH HISTORY:

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (circle any that apply and list family member beside the item, e.g., Sibling, Parent, Uncle, etc.):

Depression:

Bipolar Disorder:

Anxiety Disorders:

Panic Attacks:

Schizophrenia:

Alcohol/Substance Abuse:

Eating Disorders:

Learning Disabilities:

Trauma History:

Suicide Attempts: