Client-Intake Form

Date 1st Seen ______________________________ (Office Only: DX ________________________)

PATIENT'S NAME ___________________________

PATIENT'S ADDRESS _______________________

____

____

EMPLOYER _________________________________

OCCUPATION _______________________________

MARITAL STATUS ☐ M ☐ S ☐ W ☐ O

E-MAIL ___________________________________

DATE OF BIRTH _______________ AGE _____

HOME PHONE ____________________________

CELL PHONE ____________________________

WORK PHONE ____________________________

FAX ____________________________

SPOUSE/OTHER CONTACT _________________

ADDRESS (IF DIFFERENT) _________________

____

____

EMPLOYER _________________________________

OCCUPATION _______________________________

DATE OF BIRTH _______________ AGE _______

HOME PHONE ____________________________

CELL PHONE ____________________________

WORK PHONE ____________________________

REFERRED BY: ____________________________

INSURANCE BENEFITS: DEDUCTIBLE ________

COPAY: _____ #OF SESSIONS ALLOWED _____

EMERGENCY CONTACT ___________________

PRIMARY CARE PHYSICIAN _________________

PHONE NUMBER _________________________

PHYSICIAN'S PHONE #______________________

RELATIONSHIP _____________________________

Your appointment time is reserved specifically for you. If you are unable to keep your scheduled appointment, or need to reschedule it, please give 24 Hours notice. Without 24 hours notice, you will be billed for your appointment.

ACKNOWLEDGEMENT OF PRIVACY NOTIFICATION: Please initial to show that you have received/read your rights to privacy notice. _________________.

AUTHORIZATION TO RELEASE INFORMATION: I/We hereby authorize THE CARING CENTER to release any medical or incidental information that may be necessary for medical benefit or in processing applications for financial benefit. This includes but is not limited to my insurance company, Rehabilitation Services, Social Security Administration, and Worker's Compensation.

BY SIGNING BELOW, YOU ARE STATING THAT YOU HAVE READ THE ABOVE AND AGREE TO THE STATED CONDITIONS.

Signed ____ Date _______________

Household Members

Name	Relationship	Age	Occupation/School

Other Members of Your Immediate Family:

Name	Relationship	Age	Occupation/School

Prior Mental Health Treatment

Dates	Agency/Hospital (Indicate if inpatient or outpatient)	Provider

Medical Conditions

(Previous and Current) Include surgeries, seizures, blackouts:

____

____

____

____

Current Medications

Start Date	Name	Purpose	Dosage	Frequency	Date Stopped

General and Mental Health Information

1. How would you rate your current physical health? (Please circle one)

☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very good

Please list any specific health problems you are currently experiencing:
____

2. Are you currently experiencing chronic pain? ☐ No ☐ Yes - If yes, please describe:
____

3. How many times per week do you generally exercise? ______________________

What types of exercise do you participate in? ______________________________

4. Are you currently in a romantic relationship? ☐ No ☐ Yes - If yes, for how long? ______

On a scale of 1-10 (1 poor, 10 exceptional), how would you rate your relationship? ______

5. Do you consider yourself to be spiritual or religious? ☐ No ☐ Yes – If yes, describe your faith or belief: ____

Family Mental Health History

In the section below, identify if there is a family history of any of the following. If yes, please indicate the relationship to you: (i.e. mother, brother, uncle, etc.)

Mental Issue	**Please Circle**	**Family Member(s)**
Alcohol/substance Abuse	Yes / No	________________
Anxiety	Yes / No	________________
Depression	Yes / No	________________
Domestic Violence	Yes / No	________________
Eating Disorders	Yes / No	________________
Obesity	Yes / No	________________
Obsessive Compulsive Behavior	Yes / No	________________
Schizophrenia	Yes / No	________________
Suicide Attempts	Yes / No	________________
Other: ____________ (Please specify)	Yes / No	________________

Areas of Difficulty

Please check areas of difficulty below:

- ❏ Marriage/Relationship
- ❏ Family
- ❏ Job/School
- ❏ Friendship/Peer relationships
- ❏ Financial Situation
- ❏ Hobbies/Interests/Play Activities
- ❏ Activities of Daily Living (personal hygiene, bathing, housecleaning, etc.)
- ❏ Ability to Concentrate
- ❏ Ability to Control Temper
- ❏ Changes in Eating Habits
- ❏ Weight Loss ____ lbs. ____ (time period)
- ❏ Weight Gain ____ lbs. ____ (time period)
- ❏ Current Weight ____ Height __________
- ❏ Changes in Sleeping Habits
    - ❏ Difficulty Falling Asleep
    - ❏ Difficulty Staying Asleep
    - ❏ Early Morning Awakening
- ❏ Sexual Dysfunction
- ❏ Depressed Mood
- ❏ Decreased Energy
- ❏ Grief
- ❏ Hopelessness
- ❏ Worthlessness
- ❏ Guilt
- ❏ Anxiousness
- ❏ Panic Attacks
- ❏ Suicidal Thoughts
- ❏ Obsessions/Compulsions
- ❏ Elevated Mood
- ❏ Irritability
- ❏ Impulsiveness
- ❏ Hyperactivity
- ❏ Disruption of Thoughts
- ❏ Hallucinations
- ❏ Paranoia
- ❏ Emotional/Physical/Sexual Trauma
    - ❏ Victim ______________
    - ❏ Perpetrator ______________

What are your two most important goals for therapy?

1. ____

    ____

2. ____

    ____

Substance Use

None Used ______ Not Evaluated ________

For each substance marked indicate	TYPICAL FREQUENCY OF UES IN THE PAST 6 MONTHS						TIME OF LAST USE		
("x" ONE FOR EACH DRUG USED)	Daily	4-6 times a week	1-3 times a week	Weekend use only	Few times a month	Once a month or less	Within the past week	Within the past month	Over 1 month ago
ALCOHOL									
CANNABINOIDS (Marijuana, Hash)									
COCAINE (Powder, Crack)									
AMPHETAMINES (Crystal, Meth)									
SEDATIVES (Dalmane, Doriden, Qualude)									
MINOR TRANQUILIZERS (Valium, Xanax)									
HALLUCINOGENS (LSD, PCP, mushrooms)									
BARBITUATES (Butabarbitol, Fiornal)									
HERION									
OPIATES/NARCOTICS (Other than Heroin)									
INHALANTS (Aerosol, Gas, Glue, Paint)									
OTHER									

Have you ever been involved in a 12 step/AA program?

- ❏ Yes, currently
- ❏ Yes, but not currently
- ❏ No