CLIENT INTAKE FORM

Please complete the following intake questions. In accordance with the ethical guidelines of my counseling license, the information provided is protected under the confidentiality laws set forth by the state of Pennsylvania.

Please complete this form and bring it to your first session.

Name: _____Address_____

Email: _____.

Birth Date: ____/ _____/_____ Age_____

Gender Identification:_____Pronouns:_____

Relationship Status: Single Married Divorced Partnered Domestic Partner Widowed

Please list any children/ages: _____

Phone: home_____ Cell_____ Work_____

Education (high school, college, highest degree)_____

Military Background_____

Referred by (if any)_____

In case of emergency: Name_____ Phone _____

Please list the name, year and length of any type of counseling (individual, couple's, family, inpatient , partial hospitalization, drug, alcohol, gambling, sex addiction counseling or inpatient rehab.) you have received prior to this session._____

_____

_____

Briefly describe your reason for seeking therapy at this time. _____

_____

_____

_____

General Health and Mental Health Information

1. How would you rate your current physical health?) *(please circle)*

   Poor Unsatisfactory Satisfactory Good Very Good

2. Please identify any sleep difficulties. *(please circle)*

   Falling asleep Waking up Nightmares Insomnia

3. How many times per week do you exercise? _____Type of exercise?
_____

4. Identify any changes in your eating patterns, weight gain or loss, in the last 3 months._____

5. Please identify any significant changes in the following emotional states:

   Grief Anger Anxiety Panic Attacks Sadness Hopelessness

6. Are you currently experiencing any chronic pain?_____

7. Please identify specific life stressors that have occurred over the last year, i.e.,

job change or loss, relationship break up , death, trauma._____

_____

8. Please describe your alcohol and/or drug usage in any given week.

_____

9. Please describe your computer usage (aside from work related) ,i.e., pornography, games, social networking, general surfing, emailing._____

_____

10. Please list any types of non-traditional healing methods, current or past, i.e., acupuncture, yoga, meditation, chiropractic, herbs, reiki, massage._____

_____

11**.** Current and past psychiatric medications?_____

Family of Origin Relationships

(in six words or less)

1. Describe your relationship with mother growing up (e.g., loving, chaotic, cold, secure, insecure, never around, she was depressed, critical, hard working,self absorbed, caring, etc).

2. Describe your relationship with father growing up.....

3. How many siblings?___What was your birth order?___. Give a summary of these relationships (competitive, supportive, fighting, close, distant, etc.)

4. Describe your relationships with grandparents (close, loving, supportive, distant)

5. When I felt scared,sad,alone,sick.....the person I would go to was my_____.

6. As a child I most often felt (circle two)....

alone curious loved angry happy scared safe

7. A childhood incident that strongly influenced your life(positive or negative).

Additional Information

Current Employment (where, length, full/part time, job satisfaction)_____

_____

Spiritual Connection (church, temple, meditation, prayer, yoga, etc.)_____

What might you notice or expect will be different about you after we complete our work together?_____

_____

- *I consent to receive treatment for therapeutic services.*

- *I understand that you are not participating with my insurance company and that payment is due at time of service and failure to cancel your appointment within a 24 hour window will result in full charge for the reserved time slot.*

- *I understand that you do not have 24 hour on call services. Therefore in the case of an emergency I will call 911 or the number of my local Crisis Intervention if this need were to arise, where seconds count.*

- *I understand that my therapist and the treatment I receive are bound by HIPPA/Privacy Practices.*

- *Client Signature_____Date_____*