

CLIENT INTAKE FORM

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Please answer the following questions to the best of your abilities. These questions are to help the therapist with the therapy process. This information is held to the same standards of confidentiality as our therapy. This questionnaire will take approximately 15 minutes to complete.

Name: _____
(Last) (First) (Middle Initial)

Name of parent or guardian (if financially responsible): _____
(Last) (First) (Middle Initial)

Current address: _____

Cell Phone: _____ May we leave a message? Yes No

Other Phone: _____ May we leave a message? Yes No

Email: _____ May we email you? * Yes No

*NOTE: Emails may not be confidential

Birth date: ____/____/____ Age: _____ Gender: Male / Female / Other Identification

Are you currently in a romantic relationship? Yes No

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

On a scale from 1-10 (10 being great), how would you rate the quality of your relationship? _____

Marital status: Never Married Partnered Married Separated Divorced Widowed

Number of children: _____

Name: _____ Age: _____

Do you have siblings? Yes No How many? _____ Ages: _____

Is your Mother still living? Yes No Is your Father still living? Yes No

How did you find me? : _____

Are you currently receiving psychological services, professional counseling, psychiatric services, or any other mental health services? Yes No

Reason for change: _____

Have you had any mental health services in the past? Yes No

Reason for change: _____

Are you currently taking any psychiatric prescription medication? Yes No

If yes, please list: _____

Have you been prescribed psychiatric prescription medication in the past? Yes No

If yes, please list: _____

General Health and Mental Health Information

How is your physical health at the present time? Poor Unsatisfactory Satisfactory Good Very good

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

Are you on any medication for physical/medical issues? Yes No

If yes, please list: _____

Are you having any problems with your sleep habits? Yes No

If yes, circle those that apply:

Sleep too much Sleep too little Poor quality Disturbing dreams Other: _____

How many times per week do you exercise? _____ days _____ minutes/hours

Are there any changes or difficulties with your eating habits? Yes No

If yes, circle one:

Eating less Eating more Bingeing Restricting

Have you experienced a weight change in the last two months? Yes No

Do you consume alcohol? Daily Weekly Monthly Rarely Never
 In one month, how many times do you have four or more drinks in a 24-hour period? _____

Do you engage in recreational drug use? Daily Weekly Monthly Rarely Never

Have you felt depressed recently? Yes No
 If yes, for how long? _____

Have you had any suicidal thoughts recently? Yes No
 If yes, how often? Frequently Sometimes Rarely

Have you ever had suicidal thoughts in your past? Yes No
 If yes, how long ago? _____

How often did you have these thoughts? Frequently Sometimes Rarely

In the last year, have you had any major life changes (e.g. new job, moving, illness, relationship change, etc.)?

Quick Check

Circle the issues below that apply to you.

- | | | | |
|-------------------------------|-------------------------|-------------------|----------------------|
| Extreme depressed mood | Mood swings | Rapid speech | Extreme anxiety |
| Panic attacks | Phobias | Sleep disturbance | Hallucinations |
| Memory lapse | Alcohol/substance abuse | Body complaints | Eating disorder |
| Repetitive thoughts | Anxiety | Time loss | Repetitive behaviors |
| Homicidal thoughts | Suicide attempts | Trouble planning | |
| Difficulty with relationships | | | |
| Other: _____ | | | |

Occupational Information

Are you currently employed? Yes No
 If yes, who is your employer? _____

What is your position? _____

Are you happy in your current position? Yes No

Are you fulfilled in your current position? Yes No

Does your work make you stressed? Yes No

If yes, what are your work-related stressors? _____

What are your goals for therapy/what would you like to accomplish? _____

*******FULL PAYMENT IS DUE AT THE TIME OF EACH VISIT*******

**I ACCEPT FINANCIAL RESPONSIBILITY FOR EXPENSES INCURRED WITH
LORI OGE MA, LPC BY THE ABOVE NAMED CLIENT.**

Signature of Responsible Party

Date

Please Print your name here