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 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 Sisters? _______ How many Brothers?_______

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

Do you own any pets? ***Yes*** ***No*** What kind?____

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

Have you had any mental health services (counseling) in the past? ***Yes*** ***No***

For how long? ____

Are you currently taking any psychiatric prescription medication? ***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***:____________________

Do you exercise? ***Yes*** ***No*** How often? ____

Have there been any changes or difficulties with your eating habits? ***Yes*** ***No***
If yes, circle one:

Eating less ***Eating more*** ***Bingeing*** ***Restricting***

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

Do you consume alcohol? ***Daily*** ***Weekly*** ***Monthly*** ***Rarely*** ***Never***

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

If yes, what have you used or what do you use? ____

Emotional Wellbeing:

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 Issues	Alcohol/substance abuse	Body complaints	Eating disorder
Repetitive thoughts	Anxiety	Trouble planning	Repetitive behaviors
Homicidal thoughts	Suicide attempts	Unexplained loss of time	
Difficulty with relationships	Anger		

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?______________________________

Religious/Spiritual Information:

Do you practice a religion? ***Yes*** ***No***

If yes, what is your faith? ____

If no, do you consider yourself to be spiritual? ***Yes*** ***No***

Family Mental Health History:

The following is to provide information about your family history. Please mark each as yes or no. If yes, please indicate the family member affected.

			Family Member:
Depression	***Yes***	***No***	____________________
Anxiety Disorders	***Yes***	***No***	____________________
Bipolar Disorder	***Yes***	***No***	____________________
Panic Attacks	***Yes***	***No***	____________________
Alcohol/Substance Abuse	***Yes***	***No***	____________________
Eating Disorder	***Yes***	***No***	____________________
Learning Disability	***Yes***	***No***	____________________
Trauma History	***Yes***	***No***	____________________
Domestic Violence	***Yes***	***No***	____________________
Obesity	***Yes***	***No***	____________________
Obsessive Compulsive Behavior	***Yes***	***No***	____________________
Schizophrenia	***Yes***	***No***	____________________

Other Information:

List your strengths ____

____

____

List areas you feel you need to develop ____

____

____

What do you like most about yourself? ____

____

____

What are some ways you cope with life obstacles and stress?____

____

____

How did you find me? :____

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