

## CLIENT INTAKE FORM

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

Date: \_\_\_\_\_ Patient # \_\_\_\_\_ Clinician: \_\_\_\_\_

Name: \_\_\_\_\_ M/F Social Security # \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Age: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Race: \_\_\_\_\_ Marital: M S W D

E-mail address: \_\_\_\_\_

**EMERGENCY CONTACT NAME/TELEPHONE:** \_\_\_\_\_

Spouse: \_\_\_\_\_ Phone # \_\_\_\_\_

How many children? \_\_\_\_\_ Names and Ages of Children: \_\_\_\_\_

### **HISTORY OF PRESENT PROBLEM:**

Reason for Counseling: \_\_\_\_\_

Have you ever had the same or a similar condition? \_\_\_\_\_ Yes \_\_\_\_\_ No If yes, when and describe: \_\_\_\_\_

What would you like to accomplish out of your time in therapy? \_\_\_\_\_

How were you referred to our Office? \_\_\_\_\_

**When healthcare professionals work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office? \_\_\_\_\_**

### **PSYCHIATRIC TREATMENT HISTORY**

Are you currently receiving psychiatric services, professional counseling or psychotherapy elsewhere? ( )  
yes ( ) no

Have you had previous psychotherapy?

( ) no

( ) yes, with (previous therapist's name) \_\_\_\_\_

Are you currently taking prescribed psychiatric medication (antidepressants or others)? ( ) yes ( ) no

If yes, please list: \_\_\_\_\_(mg)

Prescribed by: \_\_\_\_\_

Have you had suicidal thoughts recently?

frequently     sometimes     rarely     never

Have you had them in the past?

frequently     sometimes     rarely     never

Have you ever been sexually, physically, verbally or emotionally abused? If so, please provide a brief detail below: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Have you ever been involved in domestic violence (child/adult), please explain:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### **MEDICAL TREATMENT HISTORY**

Do you currently have a primary physician?  yes  no

If yes, who is it? \_\_\_\_\_

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

\_\_\_\_\_

### **SOCIAL HISTORY INFORMATION**

Are you having any problems with your sleep habits?  yes  no

If yes, check where applicable:

Sleeping too little     Sleeping too much     Poor quality sleep

Disturbing dreams     other \_\_\_\_\_

Are you having any difficulty with appetite or eating habits?  no  yes

If yes, check where applicable:  Eating less     Eating more     Bingeing     Restricting

How many times per week do you exercise?

Have you experienced significant weight change in the last 2 months?  no  yes

Do you regularly use alcohol?  no     yes    Wine/Alcohol? \_\_\_\_\_

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

How often do you engage recreational drug use? ( ) daily ( ) weekly ( ) monthly ( ) rarely ( ) never

Do you smoke cigarettes or use other tobacco products? ( ) yes ( ) no

Do you have military status? \_\_\_\_\_

Are you currently in a romantic relationship? ( ) no ( ) yes

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

On a scale of 1-10 (10 being the highest quality), how would you rate your current relationship? \_\_\_\_\_

In the last year, have you experienced any significant life changes or stressors? If yes, please explain:

\_\_\_\_\_

\_\_\_\_\_

Please describe Legal History: \_\_\_\_\_

\_\_\_\_\_

**CURRENTLY SYMPTOMS:**

Extreme depressed mood	Yes / No
Dramatic mood swings	Yes / No
Rapid speech	Yes / No
Extreme anxiety	Yes / No
Panic attacks	Yes / No
Phobias	Yes / No
Sleep disturbances	Yes / No
Hallucinations	Yes / No
Unexplained losses of time	Yes / No
Unexplained memory lapses	Yes / No
Alcohol/substance abuse	Yes / No
Frequent body complaints	Yes / No
Eating disorder	Yes / No
Body image problems	Yes / No
Repetitive thoughts (e.g. obsessions)	Yes / No
Repetitive behaviors (e.g. frequent checking, hand washing)	Yes / No
Homicidal thoughts	Yes / No
Suicidal attempts	Yes / No If yes, when?
Trauma/Domestic Violence	

**OCCUPATIONAL INFORMATION**

Are you currently employed? ( ) no ( ) yes

If yes, who is your currently employer and current position? \_\_\_\_\_

If yes, are you happy with your current position? \_\_\_\_\_

Please list any work-related stressors, if any \_\_\_\_\_

**RELIGIOUS/SPIRITUAL INFORMATION**

Do you consider yourself to be religious? ( ) no ( ) yes

If yes, what is your faith? \_\_\_\_\_

Would you like to include your faith in your counseling? ( ) no ( ) yes

**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, e.g. sibling parent, uncle, etc.)

<b>Difficulty</b>	<b>Yes / No</b>	<b>Family member</b>
Depression	Yes / No	
Bipolar disorder	Yes / No	
Anxiety disorder	Yes / No	
Panic attacks	Yes / No	
Schizophrenia	Yes / No	
Alcohol/substance abuse	Yes / No	
Eating disorders	Yes / No	
Learning disabilities	Yes / No	
Trauma history	Yes / No	
Suicide attempts	Yes / No	
Chronic illness	Yes / No	

FOR OFFICE PURPOSES ONLY:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please check any and all insurance coverage and financial arrangements that may be applicable in this case:

Major Medical     EAP     Self Pay     Sliding Fee Scale  
 Medical Savings Account or Flex Plan     Other \_\_\_\_\_

Primary Insurance \_\_\_\_\_

Member ID# / Group#: \_\_\_\_\_

EAP Authorization/# of sessions: \_\_\_\_\_

**AUTHORIZATION AND RELEASE AND ASSIGNMENT OF BENEFITS:** I authorize payment of insurance benefits directly to the therapist or therapist's office staff. I authorize the therapist to release all information necessary to communicate with personal physicians and other healthcare providers and insurance payors to secure the payment of benefits. I understand that I am responsible for all costs of therapy and counseling care, regardless of insurance coverage. I understand that I am responsible to pay any co-payments at the time services are rendered.

The patient/client understands and agrees to allow this healthcare office to use his/her Patient Health Information for the purposes of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information, we encourage you to read the HIPAA NOTICE attached hereto. If there is anyone you do not want to receive your medical records, please inform our office.

I understand and agree that from time to time I may participate in therapy with a clinical intern that is under the direct supervision of the licensed mental health therapist of Healing Waters Counseling. However, I have a right to opt out of services from a clinical intern at any time.

I also understand that at my request or that of a clinician of Healing Waters Counseling, I may select to have video sessions in cases of transportation and/or illness. I also have a right to refuse video sessions.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient's Signature \_\_\_\_\_ Date: \_\_\_\_\_

Healing Waters Staff Signature \_\_\_\_\_ Date: \_\_\_\_\_