Client Intake Form

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Licensed Individual, Marriage and Family Therapist

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Please provide the following information for my records. Leave blank any question you would rather not answer. Information you provide here is held to the same standards of confidentiality as our therapy. Please fill out this form and email it to Mara.Alverson@gmail.com.

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

Email:_____

Birth Date: _____ /_____ /_____ Age: _____ Gender: □ Male □ Female

Marital Status: □ Never Married □ Partnered □ Married □ Separated

□ Divorced □ Widowed

Number of Children: _____

Local Address: _____
(Street and number)

_____
(City) (State) (Zip)

Home Phone: ( ) _____ May we leave a message? □ Yes □ No

Cell/Other Phone: ( ) _____ May we leave a message? □ Yes □ No

Referred by: _____

Are you currently receiving psychiatric services, professional counseling or

psychotherapy elsewhere? □ Yes □ No

Have you had previous psychotherapy? □No □Yes

Previous therapist's name _____

Are you currently taking prescribed psychiatric medication (antidepressants or others)?

□Yes □No If Yes, please list: _____

If no, have you been previously prescribed psychiatric medication? □Yes □No

If Yes, please list: _____

HEALTH AND SOCIAL INFORMATION

1. How is your physical health at present? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

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

_____

_____

_____

_____

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

If yes, check where applicable: □ Sleeping too little □ Sleeping too much

□ Poor quality sleep □ Disturbing dreams □ Other _____

4. How many times per week do you exercise? _____ Approximately how long each time? _____

5. Are you having any difficulty with appetite or eating habits? □ No □ Yes If yes, check where applicable: □ Eating less □ Eating more □ Binging □ Restricting

Have you experienced significant weight change in the last 2 months? □ No □ Yes

6. Do you regularly use alcohol? □ No □ Yes In a typical month, how often do you have 4 or more drinks in a 24-hour period?_____

7. How often do you engage in recreational drug use?

□ Daily □ Weekly □ Monthly□ Rarely □ Never

8. Have you had suicidal thoughts recently?

□ Frequently □ Sometimes □ Rarely □ Never

Have you had them in the past?

□ Frequently □ Sometimes □ Rarely □ Never

9. 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, how would you rate the quality of your current relationship? _____

10. In the last year, have you experienced any significant life changes or stressors:

Have you ever experienced:

Extreme depressed mood: □ No □ Yes Wild Mood Swings: □ No □ Yes

Rapid Speech: □ No □ Yes Extreme Anxiety: □ No □ Yes

Panic Attacks: □ No □ Yes Phobias: □ No □ Yes

Sleep Disturbances: □ No □ Yes Hallucinations: □ No □ Yes

Unexplained losses of time: □ No □ Yes Unexplained memory lapses: □ No □ Yes

Alcohol/Substance Abuse: □ No □ Yes Frequent Body Complaints: □ No □ Yes

Eating Disorder: □ No □ Yes Body Image Problems: □ No □ Yes

Repetitive Thoughts (e.g., Obsessions) □ No □ Yes

Repetitive Behaviors (e.g., Frequent Checking, Hand-Washing) No Yes

Homicidal Thoughts: □ No □ Yes Suicide Attempt: □ No □ Yes

OCCUPATIONAL INFORMATION:

Are you currently employed? □ No □ Yes If yes, who is your current employer/position? _____ If yes, are you happy at 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? _____ If no, do you consider yourself to be spiritual? □ 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.):

Difficulty	**Family Member**
Depression: □ No □ Yes	_____
Bipolar Disorder: □ No □ Yes	_____
Anxiety Disorders: □ No □ Yes	_____

Panic Attacks: □ No □ Yes _____

Schizophrenia: □ No □ Yes _____

Alcohol/Substance Abuse: □ No □ Yes _____

Eating Disorders: □ No □ Yes _____

Learning Disabilities: □ No □ Yes _____

Trauma History: □ No □ Yes _____

Suicide Attempts: □ No □ Yes _____

OTHER INFORMATION:

What do you consider to be your strengths?

_____

_____

_____

_____

_____

What do you like most about yourself?

_____

_____

_____

What are effective coping strategies that you've learned?

_____

_____

What are your goals for therapy?

_____

_____

_____

Is there anything else you would like me to know?

_____

_____

_____

Payment and Legal Proceedings Agreement

1. Payment is due at time of service.
2. Client is financially responsible for all sessions scheduled unless a 48-hour notice of cancellation is received.
3. On request, I will provide a "super-bill" for you to submit to your insurance company.
4. The undersigned client understands that I will not testify or appear at a deposition or in court or provide clinical records in legal matters related to separation, divorce or child custody.

I have read the above and agree to these terms.

_____ _____

(name) (date)