INTAKE INFORMATION

Client Name:_____ **Gender**:_____ **Entry Date**:_____

Address:_____

Phone:_____ Yes messages may be left here _____ No _____

Date of Birth:_____ **Email**:_____

Emergency contact:_____

Family Members:

Parents Names: _____ Date of birth:_____

_____ Date of birth:_____

Children: _____ Date of birth:_____

_____ Date of birth:_____

_____ Date of birth:_____

Who lives with you? _____

Current occupation: _____

Previous Services:
Name of Facility/Therapist Dates/Duration Contact

_____-

What was helpful? _____

What was not helpful? _____

If you wish to have the therapist contact any of these persons, please ask for a release of information form to be filled out.

Goals
What are your presenting problems? What are your personal goals for treatment?

Family History
What was it like growing up in your family of origin? Do you have a history of mental illness, substance abuse, physical illness, sexual or any kind of abuse in your family of origin?

Medical History
Do you have a history of any physical or medical conditions.

Do you have any physical or medical conditions currently? Are you under the care of a physician? When was your last physical?

Current medications:

Medication:	Dose	Frequency	Any side effects

Personal Characteristics - Please use back side of paper if needed.
Describe yourself, your strengths, your areas of struggle, your likes and dislikes

What is your spiritual background and experience

Fee Agreement

Payment is expected at time of service

Client name: _____

Session fee: $120.00 per hour unless renegotiated with therapist
Cash, checks or credit cards accepted.

No Shows: Appointments not cancelled 24 hours in advance are considered as NO SHOWS, are your personal liability and will be billed as a regular session.

Initial on line provided

_____. I am aware that a 24 hour notice is required for cancellation of appointments and that I am responsible for full payment should I cancel less than 24 hours before our appointed session.

_____ I understand payment is expected at time of service.

_____ Phone calls in excess of 10 minutes will be billed to the client's account in 15 minute increments at a rate of $15 per quarter hour.

_____ Clients are not to be in possession of alcohol, drugs, paraphernalia or weapons at any time while attending therapy sessions. Individuals who come to their session under the influence of alcohol or drugs will be asked to leave, held responsible for rescheduling and are billed for a full session.

Client signature_____ Date:_____

Therapist signature: _____ Date: _____

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Adult Form: Client Checklist – Intake

Name:_____ **Date:**_____ **Date of Birth:**_____

Below are categories in which people commonly report some difficulties. Please circle one number for each item. Your answers about yourself will help me to know you better.

Not a Problem 1	Slight Problem 2	Moderate Problem 3	Serious Problem 4	Severe Problem 5

Physical Functioning

Overeating or Weight Gain	1 2 3 4 5
Loss of Appetite or Weight Loss	1 2 3 4 5
Current Height____Weight____	
Fatigue, Lack of Energy	1 2 3 4 5
Sleeping Too Much	1 2 3 4 5
Difficulty Sleeping, Insomnia	1 2 3 4 5
Speech, Stuttering or Stammering	1 2 3 4 5
Sexual Functioning	1 2 3 4 5
Other_____	1 2 3 4 5

Experience at Work

General Performance	1 2 3 4 5
General Satisfaction	1 2 3 4 5
Lateness	1 2 3 4 5
Absenteeism	1 2 3 4 5
Negative Feelings About Work	1 2 3 4 5
Relating to Supervisors	1 2 3 4 5
Relating to Supervisees	1 2 3 4 5
Other_____	1 2 3 4 5

Feelings and Moods

Sadness	1 2 3 4 5
Discouragement, Hopelessness	1 2 3 4 5
Sudden Changes in Mood for No Apparent Reason	1 2 3 4 5
Anxiety, Nervousness, Fear, Worry	1 2 3 4 5
Feeling Angry, Irritable, Rage	1 2 3 4 5
Not Liking Self	1 2 3 4 5
Not Liking Others	1 2 3 4 5
Euphoria (Feeling "High")	1 2 3 4 5
Guilt, Being Self-Critical	1 2 3 4 5
Loss of Interest in Activities	1 2 3 4 5
Other_____	1 2 3 4 5

Life Stressors

Interpersonal Problems	1 2 3 4 5
Relating to Spouse/Similar Person	1 2 3 4 5
Financial Stress	1 2 3 4 5
Raising Children	1 2 3 4 5
Physical Abuse	1 2 3 4 5
Legal Problems	1 2 3 4 5
Other_____	1 2 3 4 5

Behavior

Difficulty with Daily Routine	1 2 3 4 5
Letting Others Take Advantage of You	1 2 3 4 5
Hyperactivity (Can't Sit Still)	1 2 3 4 5
Repeating Certain Acts Again and Again	1 2 3 4 5
Using Alcohol to Cope with Problems	1 2 3 4 5
Using Drugs to Cope with Problems	1 2 3 4 5
Lying	1 2 3 4 5
Stealing	1 2 3 4 5
Withdrawal from Others	1 2 3 4 5
Dependency (Relying on Others to Take Care of You)	1 2 3 4 5
Other_____	1 2 3 4 5

Inner Thoughts and Ideas

Thoughts that Life is Not Worth Living	1 2 3 4 5
Thoughts About Hurting Yourself	1 2 3 4 5
Fears of Looking Foolish	1 2 3 4 5
Worrying About Your Health	1 2 3 4 5
Believing You are Better than Others	1 2 3 4 5
Believing You are Inferior to Others	1 2 3 4 5
Believing You are Unable to Help Yourself	1 2 3 4 5
Concentrating	1 2 3 4 5
Experiencing Confusion	1 2 3 4 5
Memory	1 2 3 4 5
Frightening Thoughts & Daydreams	1 2 3 4 5
Fears of Criticism or Disapproval	1 2 3 4 5
Having Unwanted Thoughts Again and Again	1 2 3 4 5
Suspiciousness (Questioning Other People's Motives)	1 2 3 4 5
Other_____	1 2 3 4 5

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