Today's Date: _____

Intake Form

Client Information

Name (first and last): _____Date of Birth: _____

Email address: _____Gender (M/F): _____

Address: _____

Best phone #: _____May I leave a message? ***Yes*** ***No***

Who I am authorized to communicate with (besides you): _____

Name/Address of financially responsible party if other than the client: _____

_____

Employer/School: _____

Relationship Status: _____Race/Ethnicity: _____

Spiritual Beliefs: _____

Strengths: _____

Hobbies: _____

1– Parent/Guardian Name: _____

Preferred number: _____May I leave a voicemail? ***Yes*** ***No***

Email: _____May I email them? ***Yes*** ***No***

2 – Parent/Guardian Name: _____

Preferred number: _____May I leave a voicemail? ***Yes*** ***No***

Email: _____May I email them? ***Yes*** ***No***

(Please note that email is not considered to be a confidential form of communication)

Parents are currently: Married Divorced Remarried Never married

Custodial Guardian/Stepparents (if applicable): _____

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Primary Concerns

Main reason for seeking counseling at this time:

_____

_____

_____

Medical Care

Clinic Name: _____

Doctor's Name: _____

Phone: _____

Address: _____

May I get a release of information in order to coordinate care with your doctor? ***Yes*** ***No***

Past Psychological/Psychiatric Treatment

Have you ever received psychological, psychiatric, drug or alcohol treatment, or counseling services in the past? ***Yes*** ***No***

If applicable, which type of treatment: ***Inpatient*** ***Outpatient*** ***Both***

If you have received some form of treatment in the past, please indicate:

When: _____

Provider: _____

Reason: _____

Results: _____

Have you ever been prescribed medications for psychiatric or emotional problems? ***Yes*** ***No***

If yes, please indicate all medications (past and current):

When: _____

Medication: _____

Prescriber of the medication: _____

Reason for medication: _____

General Health

Do you have any concerns about your physical health? Please explain:

_____

_____

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

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

If yes, please circle: Eating less Eating more Binging Restricting

Have you experienced any weight changes in the last 1-2 months? ***Yes*** ***No***

Are you having any trouble with your sleep habits? ***Yes*** ***No***

If yes, please describe: _____

List of Symptoms

Please circle any of the following that have been of concern recently.

Alcohol/Substance use	Fatigue	Oppositional
Aggression	Frustrated easily	Panic attacks
Anger	Grief/Loss	Phobias
Anxiety	Hallucinations	PTSD symptoms
Bowel trouble	Headaches	Repetitive thoughts
Bullies others	Head banging	Relationship trouble
Bullied by others	Homicidal thoughts	Sadness
Compulsive	Hurting animals	Self-harm
Depressed mood	Impulsive	Sexual acting out
Defiant	Irritable	Stomach aches
Destructive	Isolation	Stealing
Difficulty focusing	Lying frequently	Suicidal thoughts/attempts
Difficulty with friends/siblings	Low self-esteem	Withdrawn
Disturbed sleep	Mood swings	Worry excessively
Eating disorder/Disordered eating		

Brief Trauma Screen

Have you ever been impacted by the following:

Domestic Violence	***Yes No***
Childhood Abuse	***Yes No***
Childhood Neglect	***Yes No***
Childhood Sexual Abuse	***Yes No***
Adult Sexual Abuse	***Yes No***
Witnessed Violence	***Yes No***
Victim of Violence	***Yes No***

Other traumatic events/situations: _____

_____

_____

Substance Use

Do you currently consume alcohol? ***Yes No***

If yes, on average how many drinks per occasion do you consume? _____

How many days per week do you consume alcohol? _____

Do you have a history of problematic use of alcohol? ***Yes No***

Have family members or friends expressed concern about your drinking? ***Yes No***

Do you currently use non-prescribed drugs or street drugs? ***Yes No***

Do you have a history of problematic drug use? ***Yes No***

Do you have a family history of alcohol or drug problems? ***Yes No***

If yes, please describe: _____

Family/Individuals in Your Household

Name	Age	Gender	Relationship	Living with you?
_____	_____	_____	_____	***Yes No***
_____	_____	_____	_____	***Yes No***
_____	_____	_____	_____	***Yes No***
_____	_____	_____	_____	***Yes No***
_____	_____	_____	_____	***Yes No***

Family Mental Health History

Issue			*Family Member(s)*
Depression	***Yes***	***No***	_____
Anxiety Disorder	***Yes***	***No***	_____
Panic Attacks	***Yes***	***No***	_____
Bipolar Disorder	***Yes***	***No***	_____
Obsessive Compulsive Behavior	***Yes***	***No***	_____
Schizophrenia	***Yes***	***No***	_____
Alcohol/Substance Abuse	***Yes***	***No***	_____
Learning Disability	***Yes***	***No***	_____
Trauma History	***Yes***	***No***	_____
Domestic Violence	***Yes***	***No***	_____
Eating disorder	***Yes***	***No***	_____

Other

What are your goals for therapy? What would you like to get out of your time in therapy?

_____

_____

_____

_____

Anything else you would like me to know?

_____

_____

_____

_____

Insurance Information

Primary Insurance Company: _____

Insurance Company (800) Number: _____

Name of Insured (Subscriber): _____ Insured's DOB: ____/____/_____

Relationship to Subscriber: _____ (Self, Spouse, Child, etc.)

ID Number: _____ Group Number: _____

Subscriber's Employer: _____ Co-Pay: $_____

Secondary Insurance Company: _____

Insurance Company (800) Number: _____

Name of Insured (Subscriber): _____ Insured's DOB: ____/____/_____

Relationship to Subscriber: _____ (Self, Spouse, Child, etc.)

ID Number: _____ Group Number: _____

Subscriber's Employer: _____ Co-Pay: $_____

I authorize Erin K. Gist, MA, LMHC, CMHS to release information to insurance carrier(s) listed and be paid directly by insurance carrier(s) for services billed. I acknowledge that I am responsible for all charges not paid by my insurance companies, including co-pays, deductibles, failed and late cancelled appointments.

Signature: _____ Date: _____