Journey to Wellness Counseling

CLIENT INTAKE PACKET

Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information.

Please fill out this form and bring it to your first session.

Name:

_____

(Last) (First) (Middle Initial)

Name of parent/guardian (if under 18 years):

_____

(Last) (First) (Middle Initial)

Birth Date: _____ /_____ /_____ Age: _____ Gender: _____

Marital Status: □ Single □ Partner □ Married □ Separated □ Divorced □Widowed

Please list any children/age: _____

Address:

_____

(Street and Number)

_____

(City) (State) (Zip)

Home Phone:_____ Cell/Other Phone:_____

E-mail: _____

Please indicate preference for appointment reminders: □ Text □ E-mail □ Call

Referred by: _____

1. Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?
   □ No
   □ Yes, previous therapist/practitioner: _____

2. Are you currently taking any prescription medication?
   □ No
   □ Yes Please list: _____
   _____

3. Have you ever been prescribed psychiatric medication?
   □ No

   □ Yes Please list and provide dates: _____
   _____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1.How would you rate your current physical health? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:
_____
_____

2. How would you rate your current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:
_____
_____

3. Please list any difficulties you experience with your appetite or eating patterns
_____
_____

4. Are you currently experiencing overwhelming sadness, grief or depression?
   □ No □ Yes
   If yes, for approximately how long? _____

5. Are you currently experiencing anxiety, panic attacks or have any phobias?
   □ No □ Yes
   If yes, when did you begin experiencing this? _____

5. Are you currently experiencing anxiety, panic attacks or have any phobias?
□ No □ Yes
If yes, when did you begin experiencing this? _____

6. Are you currently experiencing any chronic pain?
□ No □ Yes
If yes, please describe _____

7. Do you drink alcohol more than once a week?
□ No □ Yes

8. How often do you engage recreational drug use?
□ Daily □ Weekly □ Monthly □ Infrequently □ Never

9. Are you currently in a romantic relationship?
□ No □ Yes
If yes, for how long? _____
On a scale of 1-10, how would you rate your relationship? _____

10. What significant life changes or stressful events have you experienced recently:

_____

_____

_____

FAMILY MENTAL HEALTH HISTORY:

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

	Please Circle	List Family Member
Alcohol/Substance Abuse	yes/no	
Anxiety	yes/no	
Depression	yes/no	
Domestic Violence	yes/no	
Eating Disorders	yes/no	
Obesity	yes/no	
Obsessive Compulsive Behavior	yes/no	
Schizophrenia	yes/no	
Suicide Attempts	yes/no	

Other: _____

ADDITIONAL INFORMATION:

1. Are you currently employed? □ No □ Yes
   If yes, what is your current employment situation: _____
   _____
   Do you enjoy your work? Is there anything stressful about your current work?
   _____
   _____

2. Do you consider yourself to be spiritual or religious? □ No □ Yes
   If yes, describe your faith or belief: _____
   _____

3. Past or present traumatic events and/or abuse (physical, emotional, sexual)?
   □ No □ Yes
   If yes, please describe: _____
   _____

4. What do you consider to be some of your strengths?

_____

_____

_____

_____

5. What do you consider to be some of your weakness?

_____

_____

_____

_____

6. What would you like to accomplish out of your time in therapy?

_____

_____

_____

Primary Care Physician _____ Phone _____

In Case of Emergency

Name of local friend or relative_____ Phone _____

Signature

The above information is true to the best of my knowledge. I understand that I am financially responsible for any and all fees. I also authorize Journey to Wellness Counseling to obtain information from my Primary Care Physician or the person listed as an emergency contact, if necessary.

_____ _____

Client/Guardian Signature Date

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