Ferren Family Counseling LLC

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Client Intake Form

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)

Birth Date: ____ /____ /____ Age: _____ SSN:_____

Insurance: _____
ID#: _____ Group #: _____

Gender Identity: _____ □ Do Not Choose to Disclose

Race:
□ American Indian or Alaska Native □ Asian □ Black or African American □ Hispanic or Latino
□ Native Hawaiian or Other Pacific Islander □ White □ Do not choose to disclose

Marital Status:
□ Never Married □ Domestic Partnership □ Married □ Separated □ Divorced □ Widowed

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
E-mail: _____ May we email you? □ Yes □ No

Please list any children/age: _____

Referred by (if any): _____

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

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

Have you ever been prescribed psychiatric medication? □Yes □ No
Please list and provide dates: _____
_____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health?
□ 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?
□ Poor □ Unsatisfactory □ Satisfactory □ Good □ Very good

3. How many times per week do you generally exercise? _____
What types of exercise to you participate in _____

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

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

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

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

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

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

10. 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? _____

11. 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.).

Health	Self	Family Member (list)
Alcohol/Substance Abuse		
Anxiety		
Depression		
Domestic Violence		
Eating Disorders		
Obesity		
Obsessive Compulsive Behavior		
Schizophrenia		
Suicide Attempts		
Other		

If Other, please list: _____

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

_____
_____
_____
_____

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

_____
_____
_____
_____

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

_____
_____
_____
_____