Center for Cognitive Psychotherapy

Salvatore Ridente LPC, LCADC, Ed.S

Intake Form **(For couples: Please copy & complete individually)**

Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential. Please fill out this form and bring it to your first session.

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

Birth Date: _____/_____/_____ Age: _____ Gender: □ Male □ Female
Address: _____ City _____ Zip_____

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

Email: _____ May we email you? □Yes □No
*Please note: Email correspondence is not considered to be a confidential medium of communication.

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

Family Information:
Number of biological children _____ Name & Ages_____
Number of adopted children_____ Name & Ages _____
Number of step children _____Name & Ages _____

Name of Parent/Guardian (**if under 18 yrs**):_____

Name of Insurance: _____ Member ID#_____

Name of Insured on card (if other than patient) _____

Relationship to Insured _____ Co-Pay Amount _____

Social Security # _____

EMERGENCY CONTACTS:
Name_____ Relationship _____
Contact Type: __PCP ___Emergency Contact ___Guardian
Release of Information: ___ Yes ___No ___ Emergency Info ONLY Date _____
Address _____ City_____ Sate _____ Zip _____
Phone # _____ Cell _____

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EMERGENCY CONTACTS:

Name_____ Relationship _____

Contact Type: __PCP ___Emergency Contact ___Guardian

Release of Information: ___ Yes ___No ___ Emergency Info ONLY Date _____

Address _____ City_____ Sate _____ Zip _____

Phone # _____ Cell _____

How were you referred for counseling? _____

What problem or concern has brought you for counseling at this time? _____

_____

_____

_____

Duration of Problem _____

Have you received any prior mental health services (psychotherapy, psychiatric services, etc.)?

□ No

□ Yes, Previous therapist/ practitioner w/phone # _____

Are you currently taking any **Mental Health** medication?

□ Yes

□ No

Please list prescriptions taken and dosage _____

_____

_____

Do you have any medical issues?

□ No

□ Yes. Primary Care Physician w/phone # _____

Please describe _____

_____

_____

Have you ever been prescribed any prescriptions for **Medical** issues?

□ Yes

□ No

Please list and provide dates and dosage amount: _____

_____

_____

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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 experiencing:

---

3. How many times per week do you generally exercise? _____

What types of exercise do you participate in: _____

4. Please list ant 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 having 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. _____

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8. How often do you engage in 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?

_____

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

Alcohol Frequency:
___ Never ___ Less than 1x/month ___ 1-4 times pr/month ___ 2-3 times per wk. ___Daily

Usual Alcohol Consumption:
___ None ___1-2 Drinks pr/sitting ___3-4 Drinks pr/sitting ___5 or more drinks pr/sitting

Intoxication Frequency:
___Never ___ Less than 1 time pr/Month ___ 1-4 times pr/Month ___2-3 times pr/Week ___Daily

Alcohol-Related Problems: (check all that apply)
__ Binges __ Job Problem __ Sleep Disturbances __ Physical Withdrawal
__ Hangovers __ Black Outs __ Passes Out __ Seizures
__ Medical Complications __ Have you noticed changes in Tolerance

Do you have difficulty to stop after the first drink: __ Yes __ No

Does it cause problems in your relationship with others: __ Yes __ No

Do you have a concern over drinking: __ Yes __ No

If there is a problem, When did it start?
__ In the last month __ 2-3 months ago __ 6-12 months ago __More than 1 year ago __More than 5 yrs ago

History of Treatment Attempts (Check all that apply)
__ None __ Stopped on my own
__ Attended AA/other 12 step program __Attended Inpatient program
__ Attended Outpatient program __ Attended Community-Based program

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Other Substance Use Assessment (Do you use any of the following?)

	How Much are You Taking	Daily	Weekly	Occasionally
Marijuana	_____	___	___	___
Cocaine/Crack	_____	___	___	___
Heroin	_____	___	___	___
Other (specify)	_____	___	___	___

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 Disorder	yes/no	
Obesity	yes/no	
Obsessive Compulsive Disorder	yes/no	
Schizophrenia	yes/no	
Suicide Attempts	yes/no	

ADDITIONAL INFORMATION:

1. Are you currently employed: □No □Yes

If yes, what is your current employment situation? (F/T, P/T, Title etc)

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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 weaknesses?

_____

_____

_____

_____

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

_____

_____

_____

_____

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RELATIONSHIP THAT YOU ARE SEEKING HELP FOR:

For how long have you been married, cohabiting, separated, or divorced: _____

Please rate your current level of relationship satisfaction by circling the number that corresponds with your current feelings about the relationship: (extremely unsatisfied) 1 2 3 4 5 6 7 8 9 10 (extremely satisfied)

What are your expectations for counselling: _____
_____
_____
_____
_____
_____
_____

What are your treatment objectives (check all that apply): □ Improve communication □ Conflict resolution □ Parenting skills □ Problem solving □ More intimacy (emotional) □ More intimacy (sexual) □ More quality time together □ Resolve individual issues □ More autonomy □ More respect/understanding □ Power and control issues □ More hobbies □ More social contacts □ More sharing of the chores □ Help for children's behavior □ Other (specify): _____

What have you done already to address these difficulties? _____
_____
_____

Whose idea was it to come to therapy? _____

Was there a prompting event that led someone to make this call? (Why seek help now?) _____
_____
_____
_____

What are your biggest strengths as a couple?_____
_____
_____
_____

Please make at least three suggestions as to something you could personally do to improve the relationship regardless of what your partner does: _____
_____

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_____
_____
_____

Do either you or your partner drink alcohol or take drugs to intoxication? □ Yes □ No If yes for either, who, how often and what drug/alcohol? _____
_____
_____
_____

Have either you or your partner physically restrained, harmed, or injured the other person? E.g., pushed, shoved, grabbed, or slapped, etc. □ Yes □ No If yes for either partner, who, how often and what happened?_____
_____
_____

Has either of you threatened to separate/divorce as a result of the current relationship problems? □ Yes □ No If yes, who? ____Me ___Partner ___Both of us.

If married, have either of you consulted with a lawyer about divorce? □ Yes □ No If yes, who? ____Me ___Partner ___Both of us

Do you perceive that either you or your partner has withdrawn from the relationship? □ Yes □ No If yes, who? ____Me ___Partner ___Both of us

Have you or your partner ever emotionally or physically cheated on each other? □ Yes □ No □ Unsure If yes, who? ____Me ___Partner ___Both of us

How satisfied are you with the frequency of your sexual activities? (circle one) (extremely unsatisfied) 1 2 3 4 5 6 7 8 9 10 (extremely satisfied)

How satisfied are you with the quality of yours your sexual activities? (circle one) (extremely unsatisfied) 1 2 3 4 5 6 7 8 9 10 (extremely satisfied)

What is your current level of stress (overall)? (circle one) (No stress) 1 2 3 4 5 6 7 8 9 10 (extremely stressed)

What is your current level of stress in the relationship? (circle one) (No stress) 1 2 3 4 5 6 7 8 9 10 (extremely stressed)

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Name the top three concerns that you have in your relationship with your partner ("1" being the most problematic):

1. _____

2. _____

3. _____

How important is it to you to improve the quality of your relationship? (not important) 1 2 3 4 5 6 7 8 9 10 (extremely important)

How willing are you to make "working on this relationship" a priority in your life? (not willing) 1 2 3 4 5 6 7 8 9 10 (extremely willing)

Is there anything else that you would like to mention? _____

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108 North Union Avenue Entrance A-Suite 6 Cranford, New Jersey 07016

CANCELLATION & Payment POLICY

If you fail to cancel a scheduled appointment, we cannot use this time for another client and you will be billed the entire cost of your missed appointment.

A full fee is charged for missed appointments or no show cancelations with less than a 24 hour notice unless due to a documented emergency. A bill will be mailed directly to all clients who do not show up for or cancel an appointment. By signing this cancellation policy you understand that you will be charged accordingly.

Payments:

All fees (co-pay and/or out of network fees) are due upon the day of your session. Accepted forms of payment include: Check, Credit Cards or Cash.

Insurance billing:

- **In-Network**: By signing below you are allowing Salvatore Ridente, LPC, LCADC, Ed.S to bill your insurance for services rendered. .
- **Out of Network:** You are responsible to pay for the clinician's full fee the day of your session. The clinician will then give you a bill to submit to your insurance company for reimbursement.

Client Signature (Client's Parent/Guardian if under 18) _____

Today's Date_____

Clinician's Signature _____

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