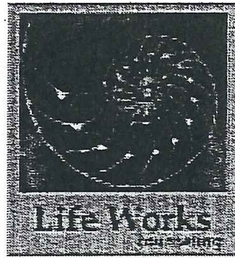

CLIENT INTAKE FORM

Please provide the following information for our records. Leave blank any question you would rather not answer. Information you provide here is held to the same standards of confidentiality as our therapy. Please print out this form and bring it to your first session or allow yourself thirty minutes prior to your appointment to complete the form in the office.

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

Name of parent/guardian (if you are a minor):

____
(Last) (First) (Middle Initial)

Birth Date: _____ /_____ /_____ Age: _______ Gender: Male Female

Marital Status:
Never Married Partnered Married Separated Divorced Widowed

Number of Children: ________

Local 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 be aware that email might not be confidential.

Referred by: ____

Are you currently receiving psychiatric services, professional counseling or psychotherapy elsewhere? Yes No

Have you had previous psychotherapy?
No Yes, at Previous therapist's name ______________________________

Are you currently taking prescribed psychiatric medication (antidepressants or others)?

Yes No If Yes, please list: ______________________________

If no, have you been previously prescribed psychiatric medication?

Yes No If Yes, please list: ______________________________

HEALTH AND SOCIAL INFORMATION

1. How is your physical health at present? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

2. Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.):

____

3. Are you having any problems with your sleep habits? No Yes

If yes, check where applicable:
Sleeping too little Sleeping too much Poor quality sleep Disturbing dreams

Other ______________________________

4. How many times per week do you exercise? __________

Approximately how long each time? __________

5. Are you having any difficulty with appetite or eating habits? No Yes

If yes, check where applicable: Eating less Eating more Binging Restricting

Have you experienced significant weight change in the last 2 months? No Yes

6. Do you regularly use alcohol? No Yes

In a typical month, how often do you have 4 or more drinks in a 24-hour period? __________

7. How often do you engage in recreational drug use?

Daily Weekly Monthly Rarely Never

8. Have you had suicidal thoughts recently? Frequently Sometimes Rarely Never

Have you had them in the past? Frequently Sometimes Rarely Never

9. Are you currently in a romantic relationship? No Yes

If yes, how long have you been in this relationship? ________________

On a scale of 1-10, how would you rate the quality of your current relationship? _______

10. In the last year, have you experienced any significant life changes or stressors:

____

Have you ever experienced:

Extreme depressed mood: No Yes

Wild Mood Swings: No Yes

Rapid Speech: No Yes

Extreme Anxiety: No Yes

Panic Attacks: No Yes

Phobias: No Yes

Sleep Disturbances: No Yes

Hallucinations: No Yes

Unexplained losses of time: No Yes

Unexplained memory lapses: No Yes

Alcohol/Substance Abuse: No Yes

Frequent Body Complaints: No Yes

Eating Disorder: No Yes

Body Image Problems: No Yes

Repetitive Thoughts (e.g., Obsessions) : No Yes

Repetitive Behaviors (e.g., Frequent Checking, Hand-Washing) : No Yes

Homicidal Thoughts: No Yes

Suicide Attempt: No Yes

OCCUPATIONAL INFORMATION:

Are you currently employed? No Yes

If yes, who is your current employer/position? ________________________

If yes, are you happy at your current position? ________________________

Please list any work-related stressors, if any: ________________________

RELIGIOUS/SPIRITUAL INFORMATION:

Do you consider yourself to be religious? No Yes

If yes, what is your faith? ________________________

If no, do you consider yourself to be spiritual? No Yes

FAMILY MENTAL HEALTH HISTORY:

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (circle any that apply and list family member, e.g., Sibling, Parent, Uncle, etc.):

Difficulty	Family Member
Depression: No Yes	________________
Bipolar Disorder: No Yes	________________
Anxiety Disorders: No Yes	________________
Panic Attacks: No Yes	________________
Schizophrenia: No Yes	________________
Alcohol/Substance Abuse: No Yes	________________
Eating Disorders: No Yes	________________
Learning Disabilities: No Yes	________________
Trauma History: No Yes	________________
Suicide Attempts: No Yes	________________

OTHER INFORMATION:

What do you consider to be your strengths?

____

What do you like most about yourself?

____

What are effective coping strategies that you've learned?

____

What are your goals for therapy?

____

Dr. Silverman

LMHC

Intake/Assessment

NAME______________________________________DATE____________________________

1. Currently... (check all that apply - click "Next" if none apply)

- ☐ I am in a personal relationship in which I frequently experience painful emotions.
- ☐ I feel trapped in a relationship that feels totally unsatisfying.
- ☐ My partner and I have severe difficulty when it comes to communicating and solving problems together.
- ☐ I am in a personal relationship that is emotionally, physically, or sexually abusive.
- ☐ I am in a romantic relationship in which either my partner or I rely on the other as our sole source of emotional well-being and self-worth.

2. During the past year, for two weeks or more... (check all that apply - click "Next" if none apply)

- ☐ I felt very sad, unhappy and low for most of the day, nearly everyday.
- ☐ The activities that used to interest me no longer provided pleasure and enjoyment.
- ☐ I had severe trouble sleeping or slept too much.
- ☐ I experienced cloudy thinking and had trouble concentrating.
- ☐ I felt slowed down compared to my usual pace.
- ☐ I felt agitated and unable to sit or stand still.
- ☐ I felt worthless.
- ☐ I had recurrent thoughts of death, dying, and suicide.
- ☐ I unintentionally gained or lost more than five percent of my original body weight.
- ☐ The above symptoms caused problems in my life or were distressing to me.
- ☐ I have experienced episodes of the above symptoms on more than one occasion, with more than two months in between episodes.

6. For at least the past six months... (check all that apply - click "Next" if none apply)

- ☐ I experienced extreme unease and apprehension about a variety of situations and experiences.
- ☐ When feeling anxious, I felt unable to reassure myself.
- ☐ I felt unusually restless, irritable, tense, or distractible.
- ☐ The anxiety and related problems caused problems in my life, and/or caused me emotional pain.
- ☐ I experienced one or more sudden episodes of extreme fear or panic in which I was trembling, sweating, experiencing heart palpitations or other physical symptoms, and felt like I was going to lose control or die.
- ☐ I have been fearful that I will experience another episode of extreme panic like I have in the past.
- ☐ I limited my behavior in an attempt to ward off another attack.
- ☐ Certain places or situations made me feel trapped or in danger.
- ☐ I avoided these places as a result.

7. Currently... (check all that apply - click "Next" if none apply)

- ☐ I suffer from a long-term, extreme fear of an object or situation (such as spiders, heights, snakes or airplane travel, among others) and recognize that fear to be excessive or unreasonable.
- ☐ The fear I experience in response to that object or situation interferes with my ability to function normally.
- ☐ I avoid the situation or object whenever possible, and experience intense anxiety and/or panic when I can't avoid it.
- ☐ I am extremely fearful of acting inappropriately or being visibly anxious in social situations, and have felt this way for some time.
- ☐ I recognize that my fear of social interaction is unreasonable or excessive.
- ☐ I avoid social situations whenever possible, but when I can't I experience intense anxiety and/or panic attacks.
- ☐ My fear of social interaction interferes with my life and/or causes me distress.

10. In general... (check all that apply - click "Next" if none apply)

- ☐ Before making decisions or doing something important, I need an excessive amount of advice and reassurance from others.
- ☐ I willingly relinquish control over my life to others.
- ☐ I am afraid to express disagreement to my friends or loved ones for fear that they will get mad at me or stop supporting me.
- ☐ I have very little faith in my ability to take care of myself or get things done without assistance.
- ☐ When one relationship ends, I feel an urgent need to be in a new relationship as soon as possible.
- ☐ I am fearful of doing things on my own.
- ☐ I experience pain, illness, or physical dysfunction that cannot be accounted for by standard medical tests.
- ☐ I am preoccupied with the idea that I suffer from a serious illness, despite professional opinions to the contrary.
- ☐ I am extremely preoccupied with the idea that a specific aspect of my appearance is defective, despite reassurances from others that there is nothing wrong with it.
- ☐ These symptoms are distressing to me or cause problems in important areas of my life.
- ☐ I have a gambling habit that feels out of control, causes me distress, or utilizes more money than I am really able to afford.

11. In general... (check all that apply - click "Next" if none apply)

- ☐ I am unwilling or unable to eat or digest enough food to maintain a minimum healthy body weight (i.e. I weigh less than 85% of the recommended weight for my height, frame, and sex).
- ☐ My self-image depends on my weight.
- ☐ I am excessively worried about becoming overweight or fat.
- ☐ I have episodes when I eat large amounts of food and feel that I cannot control how much I am eating.
- ☐ I eat until I am uncomfortably full.
- ☐ I eat when I am not hungry.
- ☐ I choose to eat alone rather than allowing others to see what/how much I eat.
- ☐ I consume food much more quickly than the norm.
- ☐ I feel angry with myself, depressed or disgusted after eating.
- ☐ These binges happen at least two times a week, and have been going on for at least six months.
- ☐ I have episodes where I vomit after eating, exercise excessively, or use laxatives or other extreme means to

14. For at least the last six months... (check all that apply - click "Next" if none apply)

- [ ] I have had a great deal of difficulty concentrating on important tasks.
- [ ] I just cannot seem to get organized.
- [ ] I get extremely restless in situations where I need to sit or work for long periods of time.
- [ ] I am often unable to bring projects I am working on to completion.
- [ ] I can't keep track of my belongings, often losing items.
- [ ] I have trouble concentrating on the details and/or make careless mistakes on work/school projects or other paperwork.
- [ ] Other people complain that I do not appear to be listening to them.
- [ ] These symptoms interfere with my life or cause me distress.
- [ ] I can recall having difficulty paying attention, sitting for long periods of time, or being disorganized in my childhood.

CANCELLATION POLICY

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

A full session fee is charged for missed appointments or cancellations with less than a 24-hour notice unless it is due to illness or an emergency. A bill will be mailed directly to all clients who do not show up for, or cancel an appointment.

Thank you for your consideration regarding this important matter.

____

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

____

Today's Date

LIMITS OF CONFIDENTIALITY

Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. Noted exceptions are as follows:

Duty to Warn and Protect
When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Abuse of Children and Vulnerable Adults
If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

Prenatal Exposure to Controlled Substances
Mental Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

Minors/Guardianship
Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

Insurance Providers (when applicable)
Insurance companies and other third-party payers are given information that they request regarding services to clients.

Information that may be requested includes, but is not limited to: types of service, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, and summaries.

I agree to the above limits of confidentiality and understand their meanings and ramifications.

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

____
Today's Date