Trish **McCoy** **LCPC CHT NCC**

Client Intake

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: ____________________________________ Initial: _________

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

Last: ____ First: ____________________________________ Initial: _________

Birth Date: ____ /____ /_____ **Age:** ________ **Gender:** ◯ Male ◯ Female

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

Spouse/Partner Name: ____

Responsible Party: (If different from above) ____

Please list any children/age: ____

Address:

Street and Number: ____

City: ____ State: __________ Zip: __________________

Phone: Home: (_______) ___________________ May I leave a message? ◯ Yes ◯ No

Cell/Other: (_______) ___________________ May I leave a message? ◯ Yes ◯ No

E-mail: _________________________________ May I email you? ◯ Yes ◯ No
Please note: Email correspondence is **NOT** considered to be a confidential medium of communication.

Referred by: (if any) ____

Have you previously received any type of mental health services (psychotherapy, psychiatric, 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?
(check one)

◯ 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?
(check one)

◯ Poor ◯ Unsatisfactory ◯ Satisfactory
◯ Good ◯ Very good

Please list any specific sleep problems you are currently experiencing:

____

____

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?
◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10

11. List any recent significant life changes or stressful events.

____

____

____

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 check one	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	_________________

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 in therapy?

____

____

____

Signature:

____

Date __________________________

Parent/Guardian Signature:

____

Date __________________________