*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: _____ Middle Initial: _____

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

Last: _____ First: _____ Middle Initial: _____

**Birth Date:** _____ **Age:** _____ **Gender:** ◯ Male ◯ Female

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

**Spouse/Partner Name:** _____

**Responsible Party:** (If client is a minor.) _____

**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) _____

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**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 _____

Clear Form