CLIENT INTAKE FORM

Please provide the following information for our records. Leave blank any question you would rather not answer, or would prefer to discuss with your therapist. Information you provide here is held to the same standards of confidentiality as our therapy.

Date:_____ Patient #_____ Clinician:_____

Name:_____M/F Social Security #_____

Home Phone: _____ Cell Phone:_____

Address:_____City:_____State:__ Zip:____

Age:_____ Birth Date:_____ Race:_____ Marital: M S W D

E-mail address:_____

EMERGENCY CONTACT NAME/TELEPHONE: _____

Spouse:_____Phone #_____

How many children?_____Names and Ages of Children:_____

_____

HISTORY OF PRESENT PROBLEM:

Reason for Counseling: _____

_____

Have you ever had the same or a similar condition? ____ Yes ____ No If yes, when and describe:

_____

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

_____

How were you referred to our Office?_____

When healthcare professionals work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office? _____

PSYCHIATRIC TREATMENT HISTORY

Are you currently receiving psychiatric services, professional counseling or psychotherapy elsewhere? ☐ yes ☐ no

Have you had previous psychotherapy?
☐ no
☐ yes, with (previous therapist's name)_____

Are you currently taking prescribed psychiatric medication (antidepressants or others)? ☐ yes ☐ no

If yes, please list: _____(mg)

Prescribed by: _____

Have you had suicidal thoughts recently?
☐ frequently ☐ sometimes ☐ rarely ☐ never

Have you had them in the past?
☐ frequently ☐ sometimes ☐ rarely ☐ never

Have you ever been sexually, physically, verbally or emotionally abused? If so, please provide a brief detail below: _____
_____
_____

Have you ever been involved in domestic violence (child/adult), please explain:
_____
_____
_____

MEDICAL TREATMENT HISTORY

Do you currently have a primary physician? ☐ yes ☐ no

If yes, who is it? _____

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

SOCIAL HISTORY INFORMATION

Are you having any problems with your sleep habits? ☐ yes ☐ no

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

Are you having any difficulty with appetite or eating habits? ☐ no ☐ yes

If yes, check where applicable: ☐ Eating less ☐ Eating more ☐ Bingeing ☐ Restricting

How many times per week do you exercise?

Have you experienced significant weight change in the last 2 months? ☐ no ☐ yes

Do you regularly use alcohol? ☐ no ☐ yes Wine/Alcohol? _____

In a typical week, how often do you have 4 or more drinks in a 24 hour period?
_____

How often do you engage recreational drug use? ☐ daily ☐ weekly ☐ monthly ☐ rarely ☐ never

Do you smoke cigarettes or use other tobacco products? ☐ yes ☐ no

Do you have military status? _____

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 (10 being the highest quality), how would you rate your current relationship? _____

In the last year, have you experienced any significant life changes or stressors? If yes, please explain:
_____
_____

Please describe Legal History: _____
_____

CURRENTLY SYMPTOMS:

Extreme depressed mood	Yes / No
Dramatic mood swings	Yes / No
Rapid speech	Yes / No
Extreme anxiety	Yes / No
Panic attacks	Yes / No
Phobias	Yes / No
Sleep disturbances	Yes / No
Hallucinations	Yes / No
Unexplained losses of time	Yes / No
Unexplained memory lapses	Yes / No
Alcohol/substance abuse	Yes / No
Frequent body complaints	Yes / No
Eating disorder	Yes / No
Body image problems	Yes / No
Repetitive thoughts (e.g. obsessions)	Yes / No
Repetitive behaviors (e.g. frequent checking, hand washing	Yes / No
Homicidal thoughts	Yes / No
Suicidal attempts	Yes / No If yes, when?
Trauma/Domestic Violence	

OCCUPATIONAL INFORMATION

Are you currently employed? ( ) no ( ) yes

If yes, who is your currently employer/position? _____

If yes, are you happy with 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? _____
Would you like to include your faith in your counseling? ( ) 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	**Yes / No**	**Family member**
Depression	Yes / No	
Bipolar disorder	Yes / No	
Anxiety disorder	Yes / No	
Panic attacks	Yes / No	
Schizophrenia	Yes / No	
Alcohol/substance abuse	Yes / No	
Eating disorders	Yes / No	
Learning disabilities	Yes / No	
Trauma history	Yes / No	
Suicide attempts	Yes / No	
Chronic illness	Yes / No	

Please check any and all insurance coverage and financial arrangements that may be applicable in this case**:**

☐ Major Medical ☐ EAP ☐ Self Pay ☐ Sliding Fee Scale
☐ Medical Savings Account or Flex Plan ☐ Other _____

Primary Insurance _____

Member ID# / Group#:_____

EAP Authorization/# of sessions: _____

AUTHORIZATION AND RELEASE AND ASSIGNMENT OF BENEFITS: I authorize payment of insurance benefits directly to the therapist or therapist's office staff. I authorize the therapist to release all information necessary to communicate with personal physicians and other healthcare providers and insurance payors to secure the payment of benefits. I understand that I am responsible for all costs of therapy and counseling care, regardless of insurance coverage. I understand that I am responsible to pay any co-payments at the time services are rendered.

The patient/client understands and agrees to allow this healthcare office to use his/her Patient Health Information for the purposes of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information, we encourage you to read the HIPAA NOTICE attached hereto. If there is anyone you do not want to receive your medical records, please inform our office.

I understand and agree that from time to time I may participate in therapy with a clinical intern that is under the direct supervision of the licensed mental health therapist of Healing Waters Counseling. However, I have a right to opt out of services from a clinical intern at any time.

I also understand that at my request or that of a clinician of Healing Waters Counseling, I may select to have video sessions in cases of transportation and/or illness. I also have a right to refuse video sessions.

Patient's Signature:_____Date:_____

Patient's Signature _____ Date:_____

Healing Waters Staff Signature _____ Date: _____