Resolve To Heal Therapeutic Associates

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 30 minutes prior to your appointment to complete the form in the office.

Name: ____
(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 msg? ☐Yes ☐No

Cell/Other Phone: ( ) - May we leave a msg? ☐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 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

Have you ever experienced cont.?

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)	☐ 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 Name
Depression	☐ No ☐ Yes	____________________________
Bipolar Disorder	☐ No ☐ Yes	____________________________
Anxiety Disorders	☐ No ☐ Yes	____________________________
Panic Attacks	☐ No ☐ Yes	____________________________

Difficulty		**Family Member Name**
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?

____

____