CLIENT INTAKE FORM

General Information

Client Name: ____

Preferred Name: ____

Pronouns (e.g., she/her/hers, he/him/his, ze/zir/zirs, they/their/theirs): ____________________

Today's Date: ____________________

Birthdate (Mo/Day/Yr): ______________________

Marital Status (circle one): Single Married Divorced Widowed Other: ______________

Current Status: ____

If a student, circle one: Full time Part time

School Attending: ____

If working, please give occupation and name of employer (address and phone not needed)

____

Address & Contact Information

Home Address:

____

Home Phone: ____________________
Okay to call: Yes / No
Okay to leave message: Yes / No

Cell Phone: ____________________
Okay to call: Yes / No
Okay to leave message: Yes / No

Emergency Contact Name: ____

Emergency Contact Phone Number: ____

Relationship to Emergency Contact: ____

May we contact your designated Emergency Contact in case of an emergency? Yes / No

Mental Health

How did you find Jill Gracely, LCSW?

Psychology Today Internet Search Referral Other

If Referral or Other, please explain: ____________________

List other therapy or counseling you have received in the past or are receiving now:

Therapist's Name	Address	Approximate Dates

In your lifetime, have you ever been in a state hospital or psychiatric facility? Yes (explain below) No

Have you ever thought about suicide? Yes (explain below and how often) No

Do you feel suicidal now? Yes (explain below) No

Medical Information

Do you have a physical disability? Yes No

If yes, please explain

____

____

____

Please list any medications you are taking below

Medication	Strength	How Many	How Often

What is the name of your current physician?

____

Have you had a serious illness in the last 12 months? Yes (explain below)   No

____

____

____

Have you ever suffered a head injury or lost consciousness?   Yes   No

If yes, when and how?

____

____

Do you have a brain injury diagnosis?   Yes   No

If yes, please explain.

____

____

Do you make use of any community-based support groups (12 step programs, AA, NA, social support)?

Yes   No

Is yes, please explain.

____

____

Symptoms

	Not at all	Mildly	Moderately	Severely
1. Depressed, sad or crying	**0**	**1 2 3**	**4 5 6 7**	**8 9 10**
2. Guilty feelings	**0**	**1 2 3**	**4 5 6 7**	**8 9 10**
3. Suicidal thoughts, plans or attempts Have you ever thought about, attempted, planned suicide? • Thought about Y N • Attempted Y N • Planned Y N If yes to any of these, when was this ________________	**0**	**1 2 3**	**4 5 6 7**	**8 9 10**
4. Changes in sleep patterns __Difficulty falling asleep __Difficulty staying asleep __Can't get up in a.m. __Nightmares	**0**	**1 2 3**	**4 5 6 7**	**8 9 10**
5. Change in weight/eating __Increase __Decrease	**0**	**1 2 3**	**4 5 6 7**	**8 9 10**
6. History of restrictive eating, dieting or purging	**0**	**1 2 3**	**4 5 6 7**	**8 9 10**
7. Insecurity or inferiority	**0**	**1 2 3**	**4 5 6 7**	**8 9 10**
8. Loss of interest in pleasurable activities	**0**	**1 2 3**	**4 5 6 7**	**8 9 10**
9. Anxious, nervous or panicky feelings	**0**	**1 2 3**	**4 5 6 7**	**8 9 10**
10. Avoiding places or situations	**0**	**1 2 3**	**4 5 6 7**	**8 9 10**
11. Repetitive thoughts or behaviors	**0**	**1 2 3**	**4 5 6 7**	**8 9 10**
12. Change in work habits __Increase __Decrease	**0**	**1 2 3**	**4 5 6 7**	**8 9 10**
13. Change in spending habits __Increase __Decrease	**0**	**1 2 3**	**4 5 6 7**	**8 9 10**

14. Anger or temper problems	**0**	**1 2 3**	**4 5 6 7**	**8 9 10**
15. Flashbacks or intrusive memories	**0**	**1 2 3**	**4 5 6 7**	**8 9 10**
16. Physical problems, pain or illness	**0**	**1 2 3**	**4 5 6 7**	**8 9 10**
17. Sexual worries or problems	**0**	**1 2 3**	**4 5 6 7**	**8 9 10**
18. Brain fog, fuzzy thinking or dissociation	**0**	**1 2 3**	**4 5 6 7**	**8 9 10**
19. Memory problems	**0**	**1 2 3**	**4 5 6 7**	**8 9 10**
20. Confused or disorganized thoughts	**0**	**1 2 3**	**4 5 6 7**	**8 9 10**

Additional Information

Do you consider yourself to be religious or spiritual? Yes No

Is yes, please provide a brief description of what that means to you

____

____

What do you consider to be some of your strengths?

____

____

What do you consider to be some of your weaknesses?

____

____

Please describe the people in your life who play a supportive or influential role

____

____

What do you hope to accomplish during your time in therapy?

____

____