Patricia M Castellanos, LMHC, C.Ht.

Licensed Mental Health Counselor & Clinical Hypnotherapist

CLIENT INTAKE FORM

Please take your time and provide the following information in as much detail as possible. It will help me get to know you better. We will start where you are at and move towards your goals. The information provided will remain confidential.

Date: _____

Client Personal Information

Client Full Name: _____

Complete Address: _____

Cell Phone: _____ Ok to call? ◯ Y ◯ N Ok to voice message? ◯ Y ◯ N

Other Phone: _____ Ok to call? ◯ Y ◯ N Ok to voice message? ◯ Y ◯ N

Preferred Phone to Text Message: _____ Ok to text message? ◯ Y ◯ N

Email: _____ Ok to send email? ◯ Y ◯ N

Note: Phone and text messages, unless password protected, are not considered to be a confidential form of communication and therefore no confidential information will be sent via these forms of communication, however, appointment reminders are sent via text message, if requested.

Date of Birth: _____ Place of Birth: _____ Age: _____ Gender: _____

Marital Status: ◯ Unmarried ◯ Married ◯ Domestic Partnership ◯ Separated ◯ Divorced ◯ Widowed

Spouse/Partner's Name: (if applicable)_____

Date of Birth: _____ Age: _____

Do you feel satisfied in your relationship: ◯ Unsatisfied ◯ Neither ◯ Satisfied ◯ Very Satisfied

Please describe any concerns: _____

_____

Children: ◯ Yes ◯ No (If Yes, please note names and ages and any relevant pregnancy, labor and delivery information)

_____

_____

Do you feel satisfied with family support: ◯ Unsatisfied ◯ Neither ◯ Satisfied ◯ Very Satisfied

Please describe any concerns: _____

_____

Level of Education: _____

Occupation:_____

How satisfied are you at work: ◯ Unsatisfied ◯ Neither ◯ Satisfied ◯ Very Satisfied

Please describe any concerns: _____

_____

In case of Emergency, who may we contact:

Name: _____ Phone: _____

Health & Medical Information

Do you have a regular physician: ◯ Y ◯ N

Name_____ Location_____

Do you have any conditions or health concerns that you would like me to be aware of:

_____

_____

Are you currently taking any medications: ◯ Y ◯ N (If Yes, please list below name and dosage)

_____

_____

Are you currently under the care of a OB/GYN physician: ◯ Y ◯ N

Name_____ Location_____

Please describe your current use, if any, of alcohol and/or non-prescription drugs: (what, how often, how much)

_____

_____

Is there any mental health and/or substance abuse history in your family? If so, please include any relatives on both maternal and paternal sides:

_____

_____

Any significant changes in sleep, appetite or eating patterns that have been of concern:

_____

_____

Have you ever tried to hurt or harm yourself: ◯ Y ◯ N (If Yes, please discuss below)

_____

_____

Mental Health Information

Do you have a mental health history including depression, anxiety, panic, eating disorder, OCD, bipolar disorder, psychotic disorder/episode, and/or a substance abuse history? If so, please describe below including any treatment you received?

_____

_____

_____

Do you have a history of physical, emotional and/or sexual trauma? If so, please describe below:

_____

_____

Perinatal Mental Health Information

Do you have a history of pregnancy or birth trauma? This may include a traumatic experience with loss, pregnancy, delivery, breastfeeding, or other childbearing or infant complications. If so, please describe below:

_____

_____

Have you experienced previous pregnancy or infant loss? If so, please describe below:

_____

_____

Have you experienced other losses that you feel have impacted you greatly? If so, please describe below:

_____

_____

Have you or are you currently experiencing any thoughts or feelings that worry you? If so, please describe below:

_____

_____

Have you or are you currently experiencing any thoughts that are scary to you about yourself or about your baby? If so, please describe below:

_____

_____

Additional Information

What are some of your strengths:

_____

_____

What are some of your hobbies and interests:

_____

_____

What are your spiritual or religious beliefs and how do they influence your life:

_____

_____

Who or what are your social and/or emotional support system(s)? If support is lacking, please describe below:

_____

_____

Do you see yourself or do others perceive you as a superwoman or perfectionist, or having perfectionism-like characteristics including setting high standards, critical self-evaluations, concerns regarding others evaluations of you, etc.?

_____

_____

Therapy & Hypnotherapy Goals

Please discuss what you would like to change or improve in your life:

_____

_____

How has this impacted your life:

_____

_____

How long has this been a concern:

_____

_____

What significant changes have you noticed lately: (Please describe both positive and negative below)

_____

_____

Have you experienced any significant life changes or stressful events recently:

_____

_____

What motivated you to begin working on this goal:

_____

_____

How will you know when you have reached your goal:

_____

_____

Who might be the first to recognize change or improvement:

_____

_____

Anything else you would like me to know:

_____

_____

Whom may I thank for referring you: (Referral or Self-referred)

Name: _____ Phone:_____

Self referral via: _____

I look forward to supporting your goals with Therapy & Hypnotherapy!