New psychotherapy clients: Please print out, fill out and bring in for your first appointment, thanks.

INTAKE INFORMATION for counseling and psychotherapy at *theZenter*

Today's date (Case ID) : _____

GENERAL INFORMATION (client or parent):

Name:_____ Address:_____
Town/City: _____ State _____ zip code: _____Date of birth: _____ SS#: _____ Home phone:_____
Business phone: _____ Cell phone:_____ *If it is ok for us to call you and leave a message. Please circle the number we may use.*
Race: _____ Gender: Female Male Age: ____ Educational level: Elementary___
GED ___ High School ___ College ___ Graduate school ___
Emergency contact person:_____ Relationship to you:_____
Address: _____ City: _____ State: ____zip_____
Phone: _____
Primary Care Physician (PCP): _____ Address: _____
Phone nr: _____ Do we have your permission to disclose information to your PCP ? Yes No

How did you hear about this office/this practitioner? _____
May we acknowledge the referral? Yes no

EMPLOYMENT:
Employer or school: _____ Length of time with current employer_____ Job title _____
Division _____ Shift _____ Job Category: Mgmt___ Profess ___ Tech ___
Admin ___ Skilled ___ Unskilled ___

FAMILY:
Marital/Legal status (please circle): Single, Married, divorced, Widowed.
If Married, is this your first marriage? Y, N. How long have you been married? _____
Spouse/Significant other: Name_____ Age _____
Occupation _____ Employer: _____
How would you describe this person? _____
Children (if applicable): Describe child:
Name:_____ age:_____ Gender___ _____
Name:_____ age:_____ Gender___ _____
Name:_____ age:_____ Gender___ _____
Name:_____ age:_____ Gender___ _____

Mother: Living Y N If yes, age ____ number of times married _____
Describe mother: _____
Father: Living Y N If yes, age ____ number of times married _____
Describe father: _____

INITIAL EVALUATION (client or parent information)
*Please fill out what you have answers to and skip the rest.*

What are you experiencing that led you to make this appointment? _____
_____
Has this been a problem before? Y N, please elaborate: _____
_____
What do you wish to change in your life? _____
_____
What do we need to know to best help you? _____
_____
Is your problem impacting your job performance Y N

HISTORY (client information):
Have you ever been in counseling/psychotherapy/support group? Y N. When? _____
With whom? _____. When was this terminated? _____. Why was it terminated? _____
Were previous treatment interventions helpful? Y N. Elaborate please: _____
_____
Have you ever been hospitalized for emotional difficulties? Y N. If yes, when? _____
Where? _____. Who was your treating physician? _____
Are you currently being seen by another behavioral health clinician? _____

If you have used, when was the approximate last date you used: Caffeine: _____
Tobacco: _____ Alcohol: _____ Marijuana: _____ Stimulants: _____
Narcotics: _____ Cocaine: _____ Other: _____
Has anyone in your family ever had an alcohol or other drug problem? _____
Has anyone ever expressed concern about your own alcohol or other drug usage? _____
Is there any history of physical or sexual abuse in your family? _____
Have any family members had psychological or emotional issues Y N
If Yes, who? _____ When? _____ For how long? _____

Please include information about any known prenatal and perinatal events (events in the lives of you and your parents before and during your birth): _____
_____

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Relevant psychological and social conditions affecting your medical and psychiatric status at present _____

GENERAL HEALTH:
Do you exercise? Y N How often and what kind? _____
When was your last physical? _____ Are you under the care of a physician?
Y N, If yes, who? _____ What are you being treated for?
_____ May we disclose information to this physician? Y N
If yes, Address of physician: _____ phone: _____
Medications taken regularly? Y N. If yes, name and dosage: _____
What for? _____
Date of initial prescription or refills: _____ Over-the-counter meds: _____

Do you have any chronic physical problems? _____
List major injuries _____ surgeries _____
illnesses _____ Allergies and adverse reactions, or sensitivities,
to foods, drugs and other substances? _____,
or no known allergies (NKA)_____. Do you have any infectious deceases ? _____

HAVE YOU RECENTLY EXPERIENCED ANY OF THE FOLLOWING?

__loss of interest
__dizziness
__trembling
__choking
__fear of dying
__vomiting
__hot flashes
__fears
__chills
__chest pain
__sweating
__forgetfulness
__racing thoughts
__feeling sad
__loss of appetite
__too much sleep
__insomnia
__dry mouth
__nausea
__fear of travel
__angry outbursts
__nightmares
__flashbacks
__painful periods
__low self-esteem
__restlessness
__gaining weight
__crying
__racing heart
__inability to enjoy life
__fainting
__feeling worthless
__trouble thinking
__arm/leg pain
__loss of weight
__easily startled
__feeling on edge
__smothering
__irritability
__feeling hopeless
__think too much
__shortness of breath
__increased appetite
__fatique
__diarrhea
__pressure in chest
__feeling keyed up
__fear of 'going crazy'
__poor concentration
__numbness/tingling
__loss of energy
__lump in throat
__sudden/intense anxiety
__feeling smothered
__thoughts of harming self or others
__difficulties falling asleep
__feeling like I have to do the same thing repeatedly
__increased night dreams __general anxiety
__waking up frequently during sleep
__ my pain medication stopped working

RESOURCES:
To whom do you turn for strength? _____
Tell us about your support systems if you have such _____
_____
Some people have religious practices that offer support, do you have such practices?___
please elaborate:_____
What have you done in the past to assist you in times of crisis? _____
_____
What are the health, wellness and leisure practices that you routinely participate in? ____
_____
_____
Where were you born? (state, county, country)_____
Where is your family from? _____. Original origin of family: (I.e. England, Denmark)
Father's side _____ Mother's side _____

LEGAL HISTORY:
Have you ever been convicted of a felony offence? _____ If yes, please elaborate _____

Thank you, please return this form to Inge Mula Myllerup-Brookhuis Cand.Psych. LPC, CEAP