Destination Life
Psychosocial Therapy Consultation
Adult & Pediatric Therapy
clientservices@mydestinationlife.com
"Regain & Reclaim Your Life"

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 directly with your therapist. Information provided shall be held to the same standards of confidentiality as our therapy session. Please fill out form & return to our clinic.

Patient Name: ______________________________________ DOB: _________________

Address: _________________________________ City: __________________ Zip: _________

Phone: ________________________________ Email: _______________________________

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: ____

Prescribed by: ____

HEALTH AND SOCIAL INFORMATION

Do you currently have a primary physician? ( ) yes ( ) no

If yes, who is it? ____

Are you currently seeing more than one medical health specialist? ( ) yes ( ) no

If yes, please list: ____

When was your last physical? ____

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

____

Are you currently on medication to manage a physical health concern? If yes, please list:

____

____

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 ______________________________

How many times per week do you exercise? _____________

Approximately how long each time? ____________________

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

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

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

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?

____

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

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

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Have you had suicidal thoughts recently?
( ) frequently ( ) sometimes ( ) rarely ( ) never

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

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:
____

____

Have you ever experienced any of the following?

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?

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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? _______________________________

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	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	

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OTHER INFORMATION

What do you consider to be your strengths? ____

____

____

What do you like most about yourself? ____

____

What are effective coping strategies that you have learned? ______________________________

____

____

What are your goals for therapy?

____

____

Patient Printed Name: ______________________________ Relation to patient: _______________

Patient/Guardian Signature: ____

Date: __________________

If Not Patient, do you have medical power of attorney? _______
(If yes, please provide supporting documentation)