Confidential Mental Health Client Intake

Name: _____

Date: _____

Referred by: _____

Date of birth: _____

Home address: _____

Mailing address: (if different from home address)
_____

E-mail address: _____

Telephone: (home) _____(office)_____(cell)_____

I give my consent that Tamara Siegel, MA, LPC may contact me via email or home telephone number:

- □ **Yes**
- □ **No**

I allow Tamara Siegel, MA, LPC to identify herself to anyone who may answer the telephone at number provided:

- □ **Yes**
- □ **No**

Family physician: _____

Address and telephone number:
_____
_____

Occupation: _____

Employer: _____

Length of employment: _____

Stress level at this position:

- □ **Low**
- □ **Medium**
- □ **High**

Are you currently attending school?

- □ **Yes**
- □ **No**

Do you have?

- □ **High School Graduate**
- □ **Technical School**
- □ **GED**
- □ **Associates Degree**
- □ **Undergraduate Degree**
- □ **Graduate Degree**

Marital status:

- □ **Single**
- □ **Married**
- □ **Divorced**
- □ **Separated**
- □ **Widow**

Have you been/are you currently in the military?

- □ **Yes (If yes what year?) _____**
- □ **No**

Have you ever been convicted of a misdemeanor or felony? If yes please explain (optional):

- □ **Yes**

  _____
  _____

- □ **No**

Describe the problem that brought you here today:

_____

_____ _____

_____

Please provide information below. If you feel uncomfortable revealing any information at this time and would rather discuss any information in person that is fine. This intake is a confidential and private record.

Briefly describe your general mental health:

_____
_____
_____
_____
_____
_____
_____

Briefly describe your general medical health:

_____
_____
_____
_____
_____
_____
_____

Are you under the care of a physician?

- □ **Yes**
- □ **No**

Do you have a medical condition, illness, limitations or disability?

- □ **Yes (please explain) _____**
- □ **No**

Are you currently or previously taking any medications?

- □ **Yes (please explain) _____**
- □ **No**

Please check all of the behaviors and symptoms that you have experienced and believe to be of concern. Please explain if necessary (there is a section at the end to write an explanation):

□ **Alcohol use/ dependence/duration / consumption**
_____
_____

□ **Drug use/ dependence/duration/ consumption**
_____
_____

□ **Anxiety/worry**
□ **Visual hallucinations**
□ **Recurring/disturbing memories**
□ **Flashbacks**
□ **Discomfort in social situations**
□ **Fatigue**
□ **Racing thoughts**
□ **Impulsivity**
□ **Withdrawal from people**
□ **Excessive energy**
□ **Lack of emotion**
□ **Computer addiction**
□ **Problems with pornography**
□ **Parenting issues/concerns**
□ **Crying spells**
□ **Guilt/shame**
□ **Anger issues, violent behavior towards others**
□ **Suspicion/paranoia**
□ **Aggression/ inappropriate**
□ **Boredom**
□ **Discomfort in social situations**
□ **Wide mood swings**
□ **Poor memory/confusion**
□ **Panic attacks**
□ **Sleep problems**
□ **Seasonal mood changes**
□ **Fear away from home**
□ **Nightmares**
□ **Sadness/depression**
□ **Eating problems**
□ **Loss of pleasure/interest**
□ **Obsessive thoughts**
□ **Gambling problems**
□ **Hopelessness**
□ **Compulsive behavior**
□ **Work/school problems**
□ **Loneliness**
□ **Relationship problems**
□ **Low-self worth**

□ **Have you ever had thoughts, made attempts or statements to hurt yourself? If yes please explain._____**

Is there any additional information that you would like the counselor to know?

Family and Developmental History

Family Mental Health Problems	Who?
Hyperactivity	
Sexually Abused	
Depression	
Manic Depression	
Suicide	
Anxiety	
Panic Attacks	
Obsessive-Compulsive	
Anger/Abusive	
Schizophrenia	
Eating Disorder	
Alcohol Abuse	
Drug Abuse	

If you have received in-patient treatment for psychiatric or emotional issues please answer the following:

Name of facility_____
Date of last in-patient treatment _____
Length of visit_____
Reason for admission _____

Name of facility_____
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Reason for admission _____

Name of facility_____
Date of last in-patient treatment _____
Length of visit_____
Reason for admission _____

If you have ever received out-patient counseling please answer the following:

Name of facility_____
Date of out-patient treatment _____
Length of visit_____
Reason for entering counseling _____
Reason for termination/leaving counseling
_____
_____

Name of facility_____
Date of out-patient treatment _____
Length of visit_____
Reason for entering counseling _____
Reason for termination/leaving counseling
_____
_____

Name of facility_____
Date of out-patient treatment _____
Length of visit_____
Reason for entering counseling _____
Reason for termination/leaving counseling
_____
_____

Insurance company _____
Secondary insurance _____
Identification number _____

I give Tamara Siegel, MA, LPC permission to contact 3rd party insurance providers if necessary:

- □ **Yes**
- □ **No**

My signature represents that the following information is valid and correct to my knowledge.

_____ _____
Client Signature Date

_____ _____
Signature of parent/legal guardian Date
(If child/minor is under 18 years of age)