

FIRST RESPONDER PSYCHOLOGY

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**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 with your therapist. Information you provide here is held to the same standards of confidentiality as our therapy.*

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Preferred Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ home / cell/ other

Okay to leave a message? Yes / No Text? Yes / No

Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How came to FRP: Internet Referral Training Other \_\_\_\_\_\_\_\_\_\_\_\_\_

**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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

For Office Use Only: Co-pay / Rate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Tell me about your family. (Include current family and family of origin)

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Who do you spend your time with? Doing what? (hobbies, interests, activities)

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Have you ever experienced any of the following?

|  |  |  |
| --- | --- | --- |
|  |  | If yes, how long? |
| 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, washing | Yes / No |  |
| Homicidal thoughts | Yes / No |  |
| Suicidal attempts | Yes / No  | If yes, when? |

**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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Do you believe you have been affected by trauma in/outside of the work? If yes, please identify the traumas and describe the effects.

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**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 |  |

**OTHER INFORMATION**

What do you consider to be your strengths? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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What do you consider to be your challenges? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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What are effective coping strategies that you have learned? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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What are your goals for therapy?

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