

FIRST RESPONDER PSYCHOLOGY

Dr. Stephanie M. Conn, Licensed Psychologist 2825

**CLIENT INTAKE FORM**

*Please provide the following information for our records. Information you provide here is held to the same standards of confidentiality as our therapy.*

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

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Preferred Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gender: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Complete 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 # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EAP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**TREATMENT HISTORY**

Are you currently receiving psychiatric services or counseling? ( ) yes ( ) no

Have you had counseling before?

( ) no

( ) yes, with (previous therapist’s name)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When? (approximately): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently taking prescribed psychiatric medication (antidepressants or others)? ( ) yes ( ) no

If yes, please list with dosage: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 ( ) Difficulty falling asleep

 ( ) Disturbing dreams ( ) Difficulty staying asleep ( ) Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many times per week do you exercise? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

What form of 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? \_\_\_\_\_\_\_\_

Why? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 you grew up in)

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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 and position? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If yes, how long have you worked there? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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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