I N T A K E F O R M

Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information.

Name: ____
(Last) (First) (Middle Initial)

Name of parent/guardian (if under 18 years):

____
(Last) (First) (Middle Initial)

Birth Date: ____ /____ /____ Age: _______ How do you identify: □ Male □ Female □ LBTQI

Marital Status:
□ Never Married □ Domestic Partnership □ Married □ Separated □ Divorced □ Widowed

Please list any children/age: ______________________________________

Address: ____
(Street and Number)

____
(City) (State) (Zip)

Home Phone: (_____)______________ May we leave a message? □Yes □No
Cell/Other Phone: (_____) ______________ May we leave a message? □Yes □No
May we text you appointment reminders? □Yes □No
E-mail: ________________________________ May we email you? □Yes □No
*Please note: Email and text correspondence is not considered to be confidential mediums of communication.

Referred by (if any): ___________________________________

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?
□ No
□ Yes, previous therapist/practitioner: ______________________________

Are you currently taking any prescription medication?
□ Yes
□ No
Please list: ____
____

Have you ever been prescribed psychiatric medication?
□ Yes
□ No
Please list and provide dates: ____
____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health? (please circle)
Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:
____

2. How would you rate your current sleeping habits? (please circle)
Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:
____

3. How many times per week do you generally exercise? __________

What types of exercise to you participate in: ___________________________________

4. Please list any difficulties you experience with your appetite or eating patterns.
____

5. Are you currently experiencing overwhelming sadness, grief or depression?
□ No
□ Yes

If yes, for approximately how long? _______________________

6. Are you currently experiencing anxiety, panic attacks or have any phobias?
□ No
□ Yes

If yes, when did you begin experiencing this? ____________________________

7. Are you currently experiencing any chronic pain?
□ No
□ Yes

If yes, please describe? ____________________________

8. How often do you drink alcohol? □ Daily □ Weekly □ Monthly
□ Infrequently □ Never

9. How often do you engage in recreational/illicit drug use? □ Daily □ Weekly □ Monthly
□ Infrequently □ Never

10. Are you currently in a romantic relationship? □ No □ Yes

If yes, for how long? ___________________

On a scale of 1-10, how would you rate your relationship? __________

11. What significant life changes or stressful events have you experienced recently:

____

____

____

FAMILY MENTAL HEALTH HISTORY:

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

	Please Circle	List Family Member
Alcohol/Substance Abuse	yes/no	
Anxiety	yes/no	
Depression	yes/no	
Domestic Violence	yes/no	
Eating Issues	yes/no	
Obsessive Compulsive Behavior	yes/no	
Schizophrenia	yes/no	
Suicide Attempts	yes/no	
Bi-polar	yes/no	

ADDITIONAL INFORMATION:

1. Are you currently employed? □ No □ Yes

If yes, what is your current employment situation:

____

Do you enjoy your work? Is there anything stressful about your current work?

____

____

2. Do you consider yourself to be spiritual or religious? □ No □ Yes

If yes, describe your faith or belief:

____

____

____

____

3. What do you consider to be some of your strengths?

____

____

____

____

4. What do you consider to be some of your weaknesses?

____

____

____

____

5. What would you like to accomplish out of your time in therapy?

____

____

____

____

6. Is there anything else you would like me to know?

____

____

____

____

Over the last two weeks, how often have you been bothered by the following? Please answer with: 0 - Not at all, 1 - Several days, 2 - More than half the days, 3 - Nearly every day

1) Little interest of pleasure in doing things ______

2) Feeling down, depressed, or hopeless ______

3) Trouble falling or staying asleep, or sleeping too much ______

4) Feeling tired or having little energy ______

5) Poor appetite or overeating ______

6) Feeling back about yourself - or that you are a failure - or that you have let yourself down ______

7) Trouble concentrating on things, such as reading the newspaper or watching television ______

8) Moving or speaking so slowly that other people could have noticed - OR - Being so fidgety/restless that you are moving around more than usual ______

9) Thoughts that you are better off dead, or of hurting yourself ______

10) Feeling nervous, anxious, or on edge ______

11) Not being able to stop or control worrying ______

12) Worrying too much about different things ______

13) Trouble relaxing ______

14) Being so restless that it's hard to sit still ______

15) Becoming easily annoyed or irritable ______

16) Feeling afraid as if something awful might happen ______

Acknowledgment of Understanding

Client Name:____
DOB: ____
SSN:____

I hereby acknowledge that I have carefully reviewed Counseling For Serenity, LLC with Brenda L. Huffstutler, MSW, LICSW's practices and procedures. I also agree to comply with all of these. These include the Disclosure Statement, the Notice of Privacy Practices, and the Office Policies and General Information Agreement for Services. All this information is available on the website and may be printed off for my own personal records. I understand that if I have questions about any of this paperwork, I can contact Brenda Huffstutler.

SERVICE AGREEMENT
I am agreeing to the following service(s) with Brenda L. Huffstutler, MSW, LICSW:

___ Individual therapy ___ Family therapy ___ Life Transitions ___ Life coaching/Career counseling
___ Parenting support ___ Infertility/Maternity support _____ Reunification _____Group Session

____
Signature of Client **Date**

____
Signature or Parent, Guardian or Personal Representative **Date**

____
*** If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).**

__________ **Client did not provide signature, dated:** _______________

__*Brenda L. Huffstutler,* **MSW LICSW**____
Therapist