SARA TAFF COUNSELING, LLC
2015 Hamilton Street, Suite 206
Allentown, PA 18104

Client Intake Paperwork

Client Name:_____**Date:**_____

Welcome! As part of beginning the therapy process, please take a few minutes to fill out these forms. The information provided will assist me in developing a deeper understanding of your situation, and will help to determine possible solutions for the difficulties you are currently experiencing. Please note that all of the information below is confidential.

Sources of stress: What are the primary issues for which you are seeking therapy?

What are the most important things you think I should be aware of, in relation to these issues?

Do you have any particular concerns or fears regarding therapy?

What are your goals for therapy?

Lastly, if you were previously in therapy, when and with whom?

Client Information:

Name:_____Date of Birth:_____

Address:_____

City:_____State:_____Zip:_____

Home #:_____Cell #:_____

On which number may we leave a confidential message? [ ] Home [ ] Cell

Email:_____

How did you hear about STC?_____

Emergency Contact Information:

Notify:_____Phone # :_____

Relationship to client:_____

Insurance Information:

Insured Name:_____Date of Birth:_____

Insurance Company:_____Insurance ID #:_____

Employer:_____Group # :_____

No Show/ Late Cancellation Payment Information:

Credit Card #: _____

Exp. Date:_____Billing Zip code:_____

Signature:_____

By signing the above, you authorize Sara Taff Counseling, LLC to charge this account to clear all patient balances

Mental Health Information

Please complete all of the information that pertains to you. It may seem long, but many questions only require a check, so it will go quickly. Thank You!

Date of Birth:_____Primary Care Physician (PCP):_____

Do you give permission for ongoing updates to be provided to your PCP? [ ] YES [ ] NO

Current symptoms Checklist: (Check once for any symptoms present, check twice for major symptoms)

[ ] Depressed Mood	[ ] Racing thoughts	[ ] Excessive worry
[ ] Unable to enjoy activities	[ ] Impulsivity	[ ] Anxiety attacks
[ ] Sleep pattern disturbances	[ ] Increased risky behavior	[ ] Avoidance
[ ] Loss of interest	[ ] Decreased need for sleep	[ ] Hallucinations
[ ] Concentration/forgetfulness	[ ] Increased libido	[ ] Suspiciousness
[ ] Change in appetite	[ ] Excessive energy	[ ] _____
[ ] Excessive guilt	[ ] Increased irritability	[ ] _____
[ ] Fatigue	[ ] Crying Spells	[ ] _____
[ ] Decreased libido	[ ] Irrational thinking	[ ] _____

Trauma History

Is there a history of abuse emotionally, sexually, physically or by neglect? [ ] YES [ ] NO

Please describe when, where, and by whom:_____
_____
_____
_____
_____
_____

Substance Use

Have you ever been treated for alcohol/drug use/abuse? [ ] YES [ ] NO

If yes, please explain:_____

If yes, where were you treated and when?_____
_____

Please check if you have ever tried the following:

	Yes	No	If yes, For how long and when did you last use?
Methamphetamine	[ ]	[ ]	_____
Cocaine	[ ]	[ ]	_____
Stimulants (pills)	[ ]	[ ]	_____
Heroin	[ ]	[ ]	_____
LSD/Hallucinogens	[ ]	[ ]	_____
Marijuana	[ ]	[ ]	_____
Pain Killers (not Rx)	[ ]	[ ]	_____
Methadone	[ ]	[ ]	_____
Sleeping pills	[ ]	[ ]	_____
Alcohol	[ ]	[ ]	_____
Ecstasy/MDMA	[ ]	[ ]	_____
Tobacco	[ ]	[ ]	_____
Other	[ ]	[ ]	_____

Health History
Any prior mental health history or official diagnosis of the following:

		Approximate Diagnosis Date/Year
Depression	**[ ]**	_____
Anxiety	**[ ]**	_____
Combat/Veteran PTSD	**[ ]**	_____
Post-partum Depression	**[ ]**	_____
OCD	**[ ]**	_____
Suicidal Ideation	**[ ]**	_____
Homicidal Ideation	**[ ]**	_____
Substance Dependency/Use	**[ ]**	_____
PTSD	**[ ]**	_____
Bipolar 1 or Bipolar 2 Dis.	**[ ]**	_____
Borderline Personality Dis.	**[ ]**	_____
ADD/ADHD	**[ ]**	_____
Other	**[ ]**	_____

Please Specify:_____

_____

_____

_____

Learning Differences such as dyslexia, dyscalculia, dysgraphia, etc. [ ]

Please Specify _____

_____

_____

Medication
Please list any and all medication you take. The dosage, frequency, reason for the medication, and roughly how long you have been taking it.

* _____
* _____
* _____
* _____
* _____
* _____
* _____
* _____
* _____
* _____
* _____

Please specify if the following apply to you

Chronic Pain Patient [ ]

Please Specify_____

_____

_____

Medication assisted treat [ ]

Ex. Ketamine, Vivitrol, Medical Marijuana, Suboxone, Methadone, Sublocade etc.

Please Specify_____

_____

_____

_____

Family Background & Childhood History

Were you adopted? [ ] YES [ ] NO

Where did you grow up?_____

List your siblings and their ages:_____

What was your father's occupation?_____

What was your mother's occupation?_____

Are your parents still together? [ ] YES [ ] NO

If not, at what age did they separate, how long have they been apart, and who did you live with?
_____

Please describe your relationship with your mother:_____

Please describe your relationship with your father:_____

At what age did you first move from your familial home?_____

Have you suffered loss within your family, both nuclear, and extended member? [ ] YES [ ] NO

Please describe who passed away, and how old you were when this occurred?_____
_____

Occupational History

Are you currently: [ ] Working [ ] Student [ ] Unemployed [ ] Disabled [ ] Retired

How long have you been in your current position?_____

What is/was your occupation?_____

Who is your employer?_____

Have you ever served in the military? [ ] YES [ ] NO

If yes, what branch and when?_____

Honorable discharge? [ ] YES [ ] NO [ ] Other; If other, please describe:_____
_____

Relationship History and Current Relationship Composition

Are you currently: [ ] Married [ ] Partnered [ ] Divorced [ ] Single [ ] Widowed

How long?_____

If you are not married, are you currently in a relationship? [ ] YES [ ] NO

If yes, How long have you been in this relationship? _____

Please describe your relationship with your spouse or significant other?_____
_____

Have you had any prior marriages? [ ] YES [ ] NO

If so, how many? _____How long? _____

Do you have any children? [ ] YES [ ] NO

If yes, please list their names/ages/genders:_____
_____

Please describe your relationship with you child(ren):_____
_____

Please list everyone that currently resides with you: _____
_____

Legal History

Have you ever been arrested? [ ] YES [ ] NO

If yes, what for and when? _____

Do you have any current legal problems? [ ] YES [ ] NO

If yes, please explain:_____