HOUSE OF TRANSFORMATION THERAPY SERVICES LLC	TELEHEALTH ONLY Canton, Ohio www.houseoftransformationtherapyservices.com **T:** 330.631.1319 **Email:** patty@houseoftransformationtherapyservices.com

INDIVIDUAL THERAPY INTAKE FORM

Note: This information is confidential.

Full Name:	Date:
Preferred Name:	
Date of Birth:	Ethnicity/Religion:
Sex/Gender assigned at birth:	Gender identified as, if applicable:
Sexual Orientation:	Preferred Pronoun, if applicable:
Cell #:	Home #
Work #:	Email:
Name of Emergency contact information and phone #:	
Home Address:	
Who do you live with?	
Employment Information:	
On sick leave, as of this date:	Approximate return to work date:
I was (FT or PT) at:	Position
Full time (FT) at:	Position:
Part-time (PT) at:	Position:
Not working because, brief description:	
Academic Information:	
Not attending school. Highest level completed:	
Full-time at: Program:	Grade/year: Typical grades:
Part-time at: Program:	Grade/year Typical grades:

PRESENTING PROBLEM:
Please state in your own words the main reason for seeking counseling:

On the scale below, please estimate how intense is your emotional distress?
(Mild) 1, 2, 3, 4, (moderate) 5, 6, 7, 8, 9, (severe) 10

Please describe:

Overall, how much do the problems affect your ability to perform at work, school, get along with others, and perform daily tasks such as household responsibilities**?**
(Mildly disruptive) 1, 2, 3, 4, (Incapacitating) 5

Please describe:

When did these problems start? What was going on in your life at that time?

Have you been in counseling before?	If so, please give names and dates of treatment and results. Was it helpful?

Stressful Life Events: Please describe any current significant or stress life events that you have been experiencing:

	No	Yes	If yes, please describe briefly
Economic problems?			
Difficulty accessing health care?			
Legal issues or crime (incl. incarceration)?			
Cultural issues?			
Family conflict or lack of support?			
Social problems?			
Educational or occupational difficulties?			
Housing problems?			
Grief or bereavement?			
Parenting issues? (New parent, Co-parenting, disagreements on discipline)			
Divorce/Separation/Marital reconciliation issue?			
Getting/recently married?			
Moving to a new home?			

	No	Yes	If yes, please describe briefly
Chronic illness or injury?			
Emotional problems (depression, anxiety, anger, etc.)?			
Retirement?			
Other, not listed?			

Behavior – please check/circle any of the following behaviors that apply to you within the past year:

Overeat	Suicidal thoughts	Can't keep a job	Crying	Impulsive reactions
Withdrawal	Vomiting	Loss of control	Aggressive behavior	Concentration difficulties
Work too hard	Lack of motivation	Self-harm	Obsessions	Hyperactive
Phobic avoidance	Procrastination	Take too many risks	Compulsions	Difficulty losing things
Suicidal attempts	Outbursts of temper	Nervous tics	Odd behavior	Organization Difficulty

Feelings – please check/circle any of the following feelings that apply to you within the past year:

Angry	Guilty	Unhappy	Annoyed	Happy	Bored	Sad
Conflicted	Restless	Depressed	Regretful	Lonely	Anxious	Hopeless
Contented	Fearful	Hopeful	Excited	Panicky	Helpless	Optimistic
Energetic	Relaxed	Tense	Envious	Jealous	Others:	

Physical – please check/circle any of the following symptoms that apply to you within the past year:

Headaches	Stomach trouble	Skin problems	Dizziness	Tics
Dry mouth	Palpitations	Fatigue	Burning or itchy skin	Muscle spasms
Twitches	Chest pains	Tension	Back pain	Rapid heart beat
Sexual disturbances	Tremors	Unable to relax	Fainting spells	Blackouts
Bowel disturbances	Hear things	Excessive sweating	Tingling	Watery eyes
Visual disturbances	Numbness	Flushes	Hearing problems	Don't like being touched

Check all that apply to you:

	Never	Rarely	Frequently	Date of last use		Never	Rarely	Frequently	
Marijuana (including medical)					Heart problems				
Tranquilizers					Nausea				
Sedatives					Vomiting				
Aspirin					Insomnia				
Cocaine					Headaches				
Painkillers					Backaches				
Alcohol					Early morning awakening				
Coffee					Fitful sleep				
Cigarettes/ Tobacco					Binge / Purge				
Narcotics					Poor appetite				
Stimulants					Eat “junk foods”				
Hallucinogens					Lack of interest in activities				
Diarrhea					Constipation				
Compulsive Exercise					High blood pressure				
Use Laxatives					Allergies				

Please list any traumatic events that you have ever experienced, witnessed, or been repeatedly confronted with in your childhood and/or as an adult (check all that apply and provide brief description if possible):

Event	**Approximate age(s)**	**Brief Description:**
Serious, life threatening illness (heart attack, etc...)?		
Physical Assault (attacked with a weapon, severe injuries from a fight, held at gunpoint, etc.)?		
Sexual assault (rape, attempted rape, forced sexual act with a weapon, etc.?)		
Military combat or lived in a war		

Event	Approximate age(s)	Brief Description:
zone?		
Child abuse (severe beatings, sexual acts with someone 5 yrs. older than you, etc.)?		
Childhood emotional or physical neglect?		
Domestic Violence/Interpersonal violence?		
Accident (serious injury or death from a car, at work, a house fire, etc.)		
Natural disaster (severe hurricane, flood, earthquake, etc.)		
Other trauma (e.g., House break in, carjacking, etc.)		

What are your positive qualities and skills? What do you like about yourself? What qualities have helped you succeed at overcoming difficulties in the past?
Please tell me about your future plans (career, personal, etc.):
How motivated do you feel to work on things in therapy? On the scale below, please estimate how motivated you feel to work on things in therapy? (Mild) 1, 2, 3, 4, (moderate) 5, 6, 7, 8, 9, (Extremely motivated) 10:
What are your goals for therapy? What would you like to achieve by attending therapy? (Include any specific behaviors, actions, habits that you would like to change noted above)
What concerns do you have about attending therapy or working on these problems?

Is there anything else that you would like to mention?

How did you find this office? (Check one)

Word of mouth	I'm a former client	Psychology Today
Google, using these words:		
Who referred you?		
Other:		

PERSONAL and SOCIAL HISTORY

MARITAL STATUS (check one)

Single Separated Cohabitating	Engaged Divorced	Married Widowed
Name and age of partner/spouse currently living with:		
Length of marriage/romantic partnership:		

Relationships	**Briefly describe your relationships with each of the following people, if applicable**
Romantic Partner/Spouse	
Step-parent(s):	
Legal guardian(s):	
Adoptive parent(s):	
Sibling(s):	
Extended family:	
Friends:	

Relationships	**Briefly describe your relationships with each of the following people, if applicable**
Colleagues or classmates:	
Total number of close, supportive relationships:	

Please list your children by name, gender, age and relationship with each child:

Child's Name, Gender, Age	**Birth Father Name**	**Briefly describe relationship with child**

	Birth Father	***Birth Mother***
If parent is living what is their age?		
State of health?		
If deceased, what was their age at the time of death?		
How old were you at the time?		
Cause of death?		
Medical/physical health conditions?		
Briefly describe what your relationship was and/or is currently like:		

Were you adopted or in foster care placement?

Age of adoption?	
Who adopted you?	
Provide brief description of what your adoption experience was like:	
Initial age in foster care?	
Reason for being placed in foster care, if known?	
Approximately, how many foster care placements were you in?	
Provide brief description of what your foster care experience(s) were like?	
Any additional information you would like me to be aware of?	

Please list any mental health history in your family of origin that you are aware of (including parents, grandparents, aunts, uncles, siblings):

Mental Health Condition	Maternal, Paternal (Parents, grandparents, Aunts, Uncles, siblings)
ADD/ADHD	
Alcohol Abuse	
Anxiety	
Autism	
Bipolar	
Depression	

Mental Health Condition	Maternal, Paternal (Parents, grandparents, Aunts, Uncles, siblings)
Eating Disorder	
Personality Disorder(s) (e.g., Borderline, Narcissism, etc.)	
Prescription Drug Abuse	
Recreational Drug Abuse	
Schizophrenia	
Suicide Attempt(s)	
Suicidal Ideations	
Suicide Completion	
Trauma/PTSD	
Other learning disorder(s)?	
Other psychiatric conditions?	

PERSONAL PSYCHIATRIC AND MEDICAL HISTORY

Do you have any current concerns about your physical health? (Yes/No):	If yes, please describe?
Primary Physician Information	
Name	
Address:	
Phone number:	
When was your last appointment?	
If female, when was your last menstrual cycle?	
If female, is your menstrual cycle regular or irregular?	
If female, how many pregnancies have you had?	
Do you engage in intercourse?	

Do you have any medical conditions, including allergies?	**If yes, please list the medical condition (including allergies) diagnosed (current or history):**
Are you currently takes any medications for your medical/physical conditions?	**If so, please list the medication and the reason for the medication?**
Do you get regular exercise? (Yes/No):	
Please describe your nightly sleep pattern:	
Do you regularly get < 7 hrs. of sleep or more than 9 hrs. of sleep each night? Please describe briefly:	
Do you have nightmares? On a regular basis? Or other sleep disturbances? Please describe briefly	
Do you have any sleep disorders?	**If yes, please provide the condition(s):**
Have you had any weigh loss or weight gain in the last 3 months? If so, how much?	
Please list any concerns you have about your eating habits?	

Psychiatrist Information	
Name	
Address:	
Phone number:	
When was your last appointment?	
Please list any medications you currently take, and what you take them for:	

MENTAL HEALTH HISTORY TREATMENT:

Have you ever been hospitalized for psychological or psychiatric reasons?

Where were you hospitalized?	**Approximate Date**	**Reason?**	**Outcome:**

Patient's Signature (or acknowledgement of electronic signature) **Date**

Patient's Printed Name

(Office Use only)

Therapist Signature **Date Received**

Patricia K Sullivan, LPCC-S, LICDC, CATP

Therapist Printed Name