CLIENT INTAKE & DEMOGRAPHICS

Name: _____ Date of Birth: _____ Age: _____
Address: _____
City: _____ State: _____ Zip: _____
Telephone: Home: _____ OK to leave a message? Yes / No
Cell: _____ OK to leave a message? Yes / No
e-mail: _____ Marital Status: _____

Employer: _____ **Occupation:** _____
Highest Level of Education: _____
Name of School (if applicable): _____ Grade: _____

EMERGENCY CONTACT

In the event that you experience an emergency and cannot be reached, please provide an individual with whom your therapist can notify or verify your safety.

Name: _____ OK to ID as Lynne Moser / therapist? Yes / No
Relationship: _____ Phone: _____

REFERRAL SOURCE

How or from whom did you learn about my practice?
_____

PRESENTING CONCERN(S)

What brings you to therapy at this time? *Include onset, duration and intensity of symptoms. What was the precipitating event and what do you hope to achieve?*

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

MEDICAL HISTORY

Primary Care Physician Name and Phone #: _____
Date of Last Physical: _____
Exam Findings: _____
Allergies: _____

May I inform your doctor that we are working together in therapy so that he/she and I can coordinate your care? ____ Yes ____ No

Medical or psychiatric condition(s) and treatment:
_____

Current medications, dosage, and name of prescribing physician:
_____
_____
_____

Hospitalizations/surgeries:
_____
_____
_____

Past psychiatric treatment (mental health/chemical dependency):
_____
_____
_____

How would you describe your mental health at this time (circle one)?

Poor Fair Good Very Good Excellent

Have you ever purposely injured or cut yourself? Yes ___ No ___ If yes, please explain:
_____
_____

Have you ever had suicidal thoughts, plans or attempts? Yes ___ No ___ If yes, please explain:
_____
_____

Prior outpatient therapy (previous therapists, dates of treatment, response to interventions):
_____
_____

SUBSTANCE USE HISTORY

Substance	Amount	Frequency	Age First Use	Age Last Use
Caffeine				
Nicotine				
Alcohol				
Marijuana				
Opioids/Narc				
Amphetamines				
Cocaine				
Hallucinogens				
Other				

Have you ever experienced alcohol or drug-induced blackouts? Yes __ No __

Has anyone ever expressed concern about your alcohol and/or drug use? Yes __ No __

Have you ever been arrested or convicted for DUI? Yes __ No __

Have you ever sold or manufactured drugs? Yes __ No __

Have you ever attended AA/NA or drug/alcohol rehab for substance abuse? Yes __ No __

PSYCHOSOCIAL INFORMATION

Support Systems (Who and where are the people that care and support you?)

_____

_____

School and Work Life

_____

_____

Marital History

_____

_____

Legal History

_____

_____

Military History

_____

_____

Spiritual/Religious Beliefs

_____

_____

FAMILY / SIGNIFICANT OTHERS

Have there been any significant changes or upsets in the family? Explain.

_____

_____

_____

How do family members get along? Explain.

_____

_____

_____

Family Members	DOB	Age	Years of Education or Highest Degree	Occupation	Lives at home?
Spouse/Partner					
Son/Daughter					
Son/Daughter					
Son/Daughter					
Sibling					
Sibling					
Sibling					
Mother					
Father					
Other					

Are there any family members with a history of the following conditions?

	Depression	Anxiety	Substance Abuse/ Addiction	Bipolar Disorder	Schizo-phrenia	Trauma	Other
Mother							
Father							
Sibling							
Sibling							
Child							
Grandparent							
Grandparent							
Other							

OTHER RELEVANT INFORMATION

Please provide any additional information that you think may be relevant to our work together.

_____
_____
_____
_____
_____
_____
_____
_____
_____

FOR CLIENTS AGES 14-18 (as per parent)

Developmental History Concerns: _____
_____

Perinatal History (details regarding labor/delivery):_____
_____

Prenatal History (medical problems in pregnancy): _____
_____