Nadine Durbach, MSW, LCSW
LCS69911

Client Intake Form

Name_____ **Date**_____

Please take a few minutes to provide information about significant areas affecting you at present and in the recent past. The information provided will help in setting goals and planning your care for psychotherapy.

Physical Issues	**no distress**					**extreme distress**		**no distress**					**extreme distress**
Fatigue	0	1	2	3	4	5	Tingling/ numbness	0	1	2	3	4	5
Pain	0	1	2	3	4	5	Eating habits	0	1	2	3	4	5
Sleep disturbance	0	1	2	3	4	5	Exercise	0	1	2	3	4	5
Sexual Issues/intimacy	0	1	2	3	4	5	Muscle tension/stress	0	1	2	3	4	5
Body changes	0	1	2	3	4	5	Breathing	0	1	2	3	4	5
Hearing problems	0	1	2	3	4	5	Energy levels	0	1	2	3	4	5
Bowel-diahrrhea/constipation	0	1	2	3	4	5	Blood pressure	0	1	2	3	4	5
Weight changes	0	1	2	3	4	5	Dizziness	0	1	2	3	4	5
Hot flashes/ Menopause	0	1	2	3	4	5	Chest pain	0	1	2	3	4	5
Headaches	0	1	2	3	4	5	Joint pain	0	1	2	3	4	5
Physical therapy/ Rehab	0	1	2	3	4	5	Back pain	0	1	2	3	4	5

Social Issues	**no distress**					**extreme distress**		**no distress**					**extreme distress**
Household activities	0	1	2	3	4	5	Parenting concerns	0	1	2	3	4	5
Caring for family	0	1	2	3	4	5	Caring for aging parents	0	1	2	3	4	5
Fertility issues	0	1	2	3	4	5	Religious/cultural community	0	1	2	3	4	5
Work issues	0	1	2	3	4	5	Generational issues-immigration	0	1	2	3	4	5
Legal concerns	0	1	2	3	4	5	Life transitions	0	1	2	3	4	5
Financial concerns	0	1	2	3	4	5	Housing issues	0	1	2	3	4	5
Family support	0	1	2	3	4	5	Complementary/alternative therapies	0	1	2	3	4	5
Friends support	0	1	2	3	4	5	Medical team/system	0	1	2	3	4	5
Community support	0	1	2	3	4	5	Sense of well being	0	1	2	3	4	5
Alcohol / Drugs	0	1	2	3	4	5	Pain relievers	0	1	2	3	4	5
Tobacco	0	1	2	3	4	5	Caffeine-coffee/tea/other	0	1	2	3	4	5

Emotional Aspects	**no distress**					**extreme distress**		**no distress**					**extreme distress**
Coping with grief and loss	0	1	2	3	4	5	Depression/sadness	0	1	2	3	4	5
Living with uncertainty	0	1	2	3	4	5	Panic attacks	0	1	2	3	4	5
Fear	0	1	2	3	4	5	Hear/see things	0	1	2	3	4	5
Managing stress	0	1	2	3	4	5	Dislike being touched	0	1	2	3	4	5
Relationship changes	0	1	2	3	4	5	Intrusive thoughts	0	1	2	3	4	5
Hope/Gratitude	0	1	2	3	4	5	Mood	0	1	2	3	4	5
Love/Forgiveness	0	1	2	3	4	5	Ability to concentrate	0	1	2	3	4	5
Happiness/Contentment	0	1	2	3	4	5	Memory problems	0	1	2	3	4	5
Anger	0	1	2	3	4	5	Nervous	0	1	2	3	4	5
Guilt	0	1	2	3	4	5	Trust/feeling safe	0	1	2	3	4	5
Anxiety	0	1	2	3	4	5	Confidence	0	1	2	3	4	5

Spiritual Issues	**no distress**					**extreme distress**		**no distress**					**extreme distress**
Religious/Spiritual support	0	1	2	3	4	5	End of life distress	0	1	2	3	4	5
Loss of faith	0	1	2	3	4	5	Religious distress	0	1	2	3	4	5
Fear of the unknown	0	1	2	3	4	5	Life review/satisfaction	0	1	2	3	4	5
Isolation/feeling alone	0	1	2	3	4	5	Meaning of life	0	1	2	3	4	5

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Name_____ **Date_____**

Please describe your family of origin (Parents; siblings; their ages now; their general mental & physical health; any important information about them that is relevant to you)

_____
_____
_____
_____

Please describe your nuclear family-the family you created (Please include the names and ages of your spouse; partner; children; pets any important information about them that is relevant to you)

_____
_____
_____
_____

What is your profession?_____ Are you employed & by whom?_____

Are you satisfied in your work? _____What do you enjoy most about your work?_____

Where & when did you go to college? _____What was your experience like?_____

Health History

Have you had a physical exam in the last six months with your doctor? Yes No

Do you have any current concerns about your physical health? If yes, please describe. Yes No

Are you under the care of a primary care doctor? If so, please list: Yes No

Physician Name_____ Telephone Number_____

Please describe any surgery/hospitalizations you have had.

Please list any prescription and over-the-counter medications or vitamins and supplements you are currently taking or have taken in the last six months.

Medication/ Vitamins/ Supplements	Side Effects

Mental Health History

Have you ever received psychiatric or psychological treatment of any kind before? Yes No
If yes, please answer the following:

When were you in treatment and for how long?

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Name_____ **Date_____**

How old were you at the time of first episode/treatment?

How many times have you been hospitalized for a psychological condition?

Who were your therapist and/or doctor during your past treatment?

Was medicine prescribed by your doctor, if yes what was it?

Have you ever attempted suicide Yes No
If yes, please explain.

Are you currently experiencing suicidal thoughts?

Substance Use History

Have you ever abused drugs or alcohol? Yes No

If yes, please complete the following:

Substances	Amount	Frequency	When? (First use, last use)

Have you received substance abuse treatment of any kind before: Yes No Outpatient Inpatient 12-step

Do you have a history of blackouts, seizures, or withdrawal symptoms: Yes No

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Other History

Have you had significant losses in your life that impacted you emotionally? Please describe your age and coping/healing?

Are you currently involved in any type of litigation? If yes, please explain.

Please list 3 life goals, aspirations, and dreams:

Please describe anything else you would like Nadine to know.