Healing Journeys, LLC

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Client Intake Form

Name: DOB: Today's Date:

Address:

City: State: Zip: Preferred Phone:

Email: Referred By:

Emergency Contact Name: Relationship:

Phone: Permission to Call: ☐Yes ☐No Restrictions:

Marital Status: ☐Single ☐Married ☐Partnered ☐Divorced ☐Widowed ☐Other

Race/Ethnicity: ☐Hispanic/Latino ☐African American/Black/African/Caribbean ☐Asian/Pacific Islander ☐Caucasian ☐Native American ☐No Disclosure ☐Other

Birth Sex: ☐Male ☐Female ☐No Disclosure ☐Other

Gender: ☐Male ☐Female ☐Genderqueer ☐Transgender ☐No Disclosure ☐Other

Preferred Pronouns: ☐He/Him/His ☐She/Her/Hers ☐They/Them/Theirs ☐Other

Medications:

Primary Care Provider: Phone:

Medical Illnesses/Surgeries:

Pregnancy History: #Live Births #Stillbirths #Miscarriages

Experienced the Loss of a Child

Nutrition Concerns:
Purge ☐Yes ☐No
Restrict ☐Yes ☐No
Overeat ☐Yes ☐No
Binge ☐Yes ☐No

Experiencing Pain: ☐Yes ☐No
Location of Pain:
How Long:
Medication for Pain:
Pain Level Today: ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 ☐+

Physical Symptoms:

- ☐ Headaches
- ☐ Muscle Tension
- ☐ Chest Pains
- ☐ Numbness
- ☐ Sweating
- ☐ Shortness of Breath
- ☐ Dizziness
- ☐ Sexual Problems
- ☐ Skin Problems
- ☐ Rapid Heartbeat
- ☐ Trembling/Shaking
- ☐ Joint/Muscle Pain
- ☐ Heat Pounding
- ☐ Diarrhea
- ☐ Fainting
- ☐ Fatigue
- ☐ Vision Changes
- ☐ Blackouts
- ☐ Chills/Hot Flashes
- ☐ Stomach Aches
- ☐ Nausea

Other:

Client Intake Form

Top Three Stressors:

1.

2.

3.

Mood (Past 1-2 Weeks):

- ☐ Calm
- ☐ Happy
- ☐ Sad
- ☐ Angry
- ☐ Anxious
- ☐ Frustrated
- ☐ Worried
- ☐ Hopeless
- ☐ Helpless
- ☐ Excited
- ☐ Other

Behavioral Symptoms (Past Month):

- ☐ Sleep
- ☐ Enjoying Life
- ☐ Motivation
- ☐ Shame
- ☐ Guilt
- ☐ Concentration
- ☐ Racing Thoughts
- ☐ Loss of Sex Drive
- ☐ Impulsiveness
- ☐ Fatigue
- ☐ Poor Judgment
- ☐ Appetite Change
- ☐ Periods of High/Low
- ☐ Strange Thoughts
- ☐ Strange Behavior
- ☐ Low Energy
- ☐ Anxious
- ☐
- ☐
- ☐
- ☐
- ☐

Notes:

Risk Assessment:

	Yes	No	Recently	Today
Been so distressed you seriously wished to end your life?				
Do you have a specific plan how you would kill yourself?				
Do you have access to weapons/means of hurting self?				
Have you made a serious suicide attempt?				
Have you purposely done something to hurt yourself?				
Have you heard voices telling you to hurt yourself?				
Relatives who attempted or committed suicide?				
Thoughts of killing or seriously hurting someone?				
Heard voices telling you to hurt others?				

Any hospitalizations for mental health purposes? ☐ Yes ☐ No

If yes, when and for what reason?

Have you had any previous counseling? ☐ Yes ☐ No

If yes, with whom and when?

Social History:

Are your parents divorced? ☐ Yes ☐ No

Briefly describe your childhood (happy, chaotic, troubled):

Are childhood events contributing to current problems? ☐ Yes ☐ No

Have you experienced any abuse (physical, sexual, verbal)? ☐ Yes ☐ No

How satisfied are you with your current family life? ☐ Satisfied ☐ Unsatisfied

How satisfied are you with the support received from family and friends? ☐ Satisfied ☐ Unsatisfied

How satisfied are you with your quality of life? ☐ Satisfied ☐ Unsatisfied

Do you enjoy leisure/recreational actives? ☐ Yes ☐ No Why/Why Not

Are you Spiritual? ☐ Yes ☐ No If yes, importance to you?

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Education/Work History:

Years of Education? Degree(s)?

How many jobs held? Been Fired? ☐ Yes ☐ No

Do you have performance problems or difficulties with boss? ☐ Yes ☐ No

How satisfied are you with your current occupation? ☐ Satisfied ☐ Unsatisfied

Substance Use/Abuse:

	Yes	No	Past	Currently
Regularly use alcohol (more than twice a week)?				
Had trouble (legal, family, work) because of alcohol?				
Felt you should cut down on drinking?				
Felt bad or guilty about your drinking?				
Ever had a drink first thing in the morning?				
Use medications not prescribed to you?				
Taken more than the recommended daily dose?				
Used any product or other means to get "high"?				

Habits:

Do you smoke or chew tobacco regularly? ☐ Yes ☐ No If so, how much?

Do you drink caffeinated drinks regularly? ☐ ☐ No If so, how much?

Do you exercise on a regular basis? ☐ Yes ☐ No If so, how much?

Do you have problems with gambling? ☐ Yes ☐ No

Do you have other potentially harmful habits you want to change? ☐ Yes ☐ No

Describe

Reason for Seeking Therapy:

Goals for Therapy:

1.

2.

3.

Client Signature | Client Printed Name | Date

Legal Guardian Signature | Legal Guardian Printed Name | Date