Paws for Reflection Ranch

5431 Montgomery Road, Midlothian, Texas 76065 * 972-775-8966
pawsforreflectionranch@att.net

CLIENT INTAKE FORM

Name_____ Date of 1st Appointment_____ Therapist:_____

Date of Birth _____ Age _____ Gender: Male _____ Female _____

MEDICAL HISTORY

Name of Primary Care Physician: _____

Physician's Address:_____Physician's Phone: _____

I may need to interact with your primary care physician to coordinate care. Do you give me consent to discuss your care with the above named doctor? (Circle One) **YES** **NO**

Please sign here for either answer:_____

Date of last medical evaluation:_____ Date of next appointment:_____

Current medications being taken:

1)_____ Dosage/Freq_____ Start Date_____Purpose_____

2)_____ Dosage/Freq _____ Start Date_____Purpose_____

3)_____ Dosage/Freq _____ Start Date_____Purpose_____

Prescribed by: _____

Has the client ever been hospitalized for medical or psychiatric reasons? (Circle one) **YES** **NO**

Hospital	Mo/Yr	Reason
_____	_____	_____
_____	_____	_____

Does the client use recreational drugs? (Circle One) **YES** **NO** If no, has the client used in the past? (Circle One) **YES** **NO**

If yes, when did the client stop? _____

Type of Drug	How much	How often
_____	_____	_____
_____	_____	_____

Does the client drink alcohol? (Circle One) **YES** **NO** If no, did the client drink previously? (Circle one) **YES** **NO**

Type of Alcohol	How much	How often
_____	_____	_____
_____	_____	_____

Does the client smoke cigarettes? (Circle One) **YES** **NO**

Does the client use other forms of tobacco? (Circle One) **YES** **NO** If yes, what kind? _____

Describe any important medical history, chronic ailments, or other health problems the client experiences:

_____

_____

Describe any health problems or important medical history about the client's immediate family members and relatives, including chronic ailments: _____

_____

Describe any mental health concerns of the client's close relatives:_____

_____

_____

SCHOOL / WORK HISTORY

Describe any current or past developmental, academic or behavioral problems _____

_____

What was the last year of school the client completed? _____ If the client did not complete high school,

please explain:_____

What school does the client currently attend? _____ Is the client homeschooled? (Circle One) **YES NO**

Please list schools: (1) currently attending, (2) last attended, (3) graduated:

(1) School(s)_____ Year(s)_____

(2) School(s)_____ Year(s)_____

(3) School(s)_____ Year(s)_____

Current occupation: _____

Describe occupation/work influence in client's life: _____

_____

FAMILY HISTORY

Please check all information which applies to the client's biological parents:

MOTHER
____ living
____ deceased
____ married
____ divorced
____ remarried ____# of times

FATHER
____ living
____ deceased
____ married
____ divorced
____ remarried ____# of times

List all who live with client: _____

List any person that client consider to be a parent (step-parent, grandparent, etc.):_____

_____

List any custody and/or visitation orders in place with the client: _____

_____

Have current custody/guardianship/conservatorship paperwork been provided to your provider? **YES NO**

List where client's parents live: Mother _____ Father _____

Describe the relationship with the client's mother:

Currently: _____

_____

In the past: _____

_____

Describe the relationship with the client's father:

Currently: _____

_____

In the past: _____

_____

List first names and ages of brothers & sisters, and others living in the home, including the client:

Name	Age	Relationship (natural, step, half, etc.)
_____	_____	_____
_____	_____	_____
_____	_____	_____

Describe any alcohol/drug use in the home with which client was raised (include dates): _____

_____

Describe any sexual/physical/emotional abuse in the home with which client was raised (include dates):_____

_____

MARITAL HISTORY (of Client if an adult and of Parent of Client if a minor)

Marital status: ___Single/never married ___Married ___Separated ___Divorced ___Widowed ___Living w/someone

If currently married, when was the client married? _____ If living w/someone, how long? _____

Please list any children of Client:

Name	Age	Relationship (biological/step)	Lives with
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

MENTAL HEALTH HISTORY

Please check any of the following that describe all that apply to client:

____sad ____anxious ____depressed ____frightened ____guilty ____angry ____ashamed ____aggressive ___resentful

____worthless ___tearful ____irritable ____confused _____mood swings _____aggressive _____hopeless ___compulsive

Other:_____ _____

_____

Please check any of the following risk-taking behaviors that apply to client:

____speeding ____gang involvement ____skipping school ____dropping out ____dangerous dieting ____cutting

____stealing ___unprotected sex ____running away ____bullying ____fire starting ____hurting animals

____restricted food intake ____over-exercising ___ over-spending ___ pornography ___gambling ___ selling drugs

Other:_____

Please check all currently or previously used: ____ beer ____ wine ____ liquor ____pot ____ cocaine ____ other_____

List activities, hobbies, interests of the client: _____

_____

Describe client's support network: _____

_____

Describe client's spirituality influence: _____

_____

Describe culture influence: _____

_____

Describe the client's exercise routine: _____

Describe the client's sleep patterns:_____

Check all challenge areas: ____falling asleep ___staying asleep ___waking up ___bedwetting ___taking naps

Describe client's eating habits: _____

Client's sexual identification: _____ Client's preferred pronouns: _____

Has the client ever **considered suicide** in connection to their **current** problems? (Circle One) **YES NO**

Describe with dates:_____

Has the client **considered suicide** in the **past**? (Circle One) **YES NO**

Describe with dates:_____

Has the client **attempted suicide recently** or in the **past**? (Circle One) **YES NO**

Describe with dates:_____

Has the client had any **homicidal thoughts recently** or in regard to their **current** problem? (Circle One) YES NO

Describe with dates:_____

Has the client ever **considered homicide** in the **past**? (Circle One) YES NO

Describe with dates:_____

Include any other **safety** related information: _____

_____

LEVEL OF FUNCTIONING

List or describe any current challenges or problems in daily psychological, social or occupational functioning (i.e. isolation from friends/family, significant difficulty getting to work or completing daily tasks, severe financial strain, recent divorce, and problems with supervisor, etc.): _____

_____

_____

THOUGHTS: Please check any of the following that apply.

The client…

_____ sometimes hears voices even though no one nearby is talking

_____ sometimes feels that there are external forces controlling them

_____ sometimes feels that other people control their thoughts

_____ sometimes has the same thought over and over and cannot control it

_____ sometimes feels that someone is out to hurt them or do something against them

_____ sometimes unable to control behavior

Please explain:_____

_____

List any other information regarding the client or the client's family that you would like the therapist to know? You may also use this space to complete earlier responses. _____

_____

_____

List the reason seeking therapy services: _____

_____

_____

List the client's strengths:

1)_____

_____

2)_____

_____

3)_____

_____

Other: _____

_____

List the client's therapy goals:

1)_____

_____

2)_____

_____

3)_____

_____

Other: _____

_____

THANK YOU!