

Dr. Susan Howard-Perry

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**CONFIDENTIAL INTAKE FORM**

**Section A.**

Client Name:

Gender: M\_\_ or F\_\_ DOB: SSN:

Address:

 (Street, Apt. #, City, State, Zip)

How long at this address?

Phone (H): Phone (W):

Phone (C): Email:

How do you prefer to be reached?

Employer’s Name:

Employer’s Address:

Primary Care Physician’s Name:

Physician’s Phone:

Did this Physician refer you to us? Y\_\_ or N\_\_

Emergency Contact Name: Phone #:

**Section B.**

The Client is: \_\_In a Relationship \_\_Single \_\_Married \_\_Separated \_\_Divorced \_\_Widowed

Number of children and their ages:

**Section C.**

Credit Card #: Exp. Date. CVV:

Cardholder Name: Zip Code:

**Section D.**

If married or in a relationship, how long?

Spouse/Partner’s Name: Spouse’s DOB:

**Section E.**

Specifically, what problems do you want to address during therapy?

What are you hoping to accomplish with counseling (i.e. What are your mental health goals)?

Have you received prior counseling or treatment? Y\_\_ or N\_\_

If yes, when? Who treated you?

Have you been diagnosed with a mental illness? Y\_\_ or N\_\_ If yes, please list the diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is there any history of mental health issues within your family: Y\_\_ or N \_\_ If Yes, what is their relationship to you and what was their diagnosis?

Have you ever suffered a TBI (Traumatic Brain Injury i.e. loss of consciousness, concussion, stroke, etc.)? Y \_\_ or N \_\_

If Yes, please provide the date, nature of injury and any current symptoms:

Do you experience auditory or visual hallucinations? Y \_\_ or N\_\_ If Yes, please explain:

Have you ever verbalized suicidal or homicidal thoughts or plans? Y \_\_ or N \_\_

Have you ever attempted suicide? Y\_\_\_ or N\_\_\_ If you answered “Yes” please include the dates, how the attempt was made, and if you were hospitalized or not.

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been hospitalized for mental health issues? Y \_\_ or N \_\_ If Yes, please provide the dates, diagnosis and circumstances of the hospitalization:

Medications (Please list ALL medications you are currently taking both prescription and over the counter):

Physical Health (Please list ALL injuries, medical problems, physical disabilities or any other physical limitation or trauma you may have or had):

Eating Habits (Please briefly describe your eating habits, i.e. typically fast food, coffee, soda, etc.):

Sleeping Habits (Approximately how many hours of sleep do you receive each night, do you have difficulty sleeping, etc?)

Spiritual Beliefs:

**Please use the space below if needed.**