PRECISION TRAUMA THERAPY CENTER, LLC
9217 OH-43, Suite 240
Streetsboro, OH 44241
330-500-0921
admin@precisiontraumatc.com

INTIAL INTAKE INFORMATION

Client Information

Client [legal] Name: _____Date of Birth: _____ Age: _____

Client Preferred Name: _____

Address: _____

Phone: _____ Email: _____

Preferred Method of Contact: Phone Call _____ Text/SMS_____ Email_____

Marital/Relationship Status: Single____ Married____ Separated_____ Divorced_____ Widowed_____

Education Level: _____ Employment Status: _____

Living Situation: _____

Gender Identity (if relevant to care): _____

Sexual Orientation (if relevant to care): _____

Emergency Contact Person: _____Relationship to Client: _____

Address: _____Phone: _____

Referral Source: Website_____ Insurance Directory_____ Physician_____ Psychiatrist_____

Therapist_____ Friend/Family Member_____ Other (specify)_____

Insurance Information (if applicable skip if it doesn't apply)

Insurance Provider: _____ Member ID: _____

Group Number: _____ Policy Holder Name: _____

Policy Holder DOB: _____ Relationship to Policy Holder: _____

Reason for Seeking Therapy

What Brings You In?

_____

_____

_____

_____

What Concerns Would You Like Help With?

_____

_____

_____

When Did These Concerns Begin?

_____

_____

Symptom Checklist (check ONLY what applies)

☐ Emotional Dysregulation

☐ Intrusive Memories

☐ Fear-Based-Responses (e.g. anger, depression, anxiety, mistrust, panic, somatic symptoms etc.)

☐ Significant stress

☐ Relationship Problems

☐ Sleep Difficulties (e.g. nightmares, insomnia, parasomnia, etc.)

☐ Grief

☐ Other (specify): _____

_____

Mental Health History

Previously Been to Counseling: Yes_____ No_____

Previously Diagnosed with Mental health Disorder: Yes____ No___ If yes specify: _____

_____

Medical History

Current Conditions: _____

_____

Current Medications: _____

_____

Substance History

Do you use Alcohol: Yes____ No____ If yes specify: _____

Do you use Recreational/Illicit Drugs: Yes___ No___ If yes specify: _____