THE CENTER FOR HEALING JOURNEYS

INTAKE

DATE:

Confidential Client Information

Welcome to our practice. We want to make the most of each appointment you have with us. One way of doing this is for you to write down some basic information in advance of your first appointment. Please fill out the following as completely as possible. This information is confidential.

1. **Name: _____**

2. **Address:**
   Street/PO box_____

3. **City: _____ State: _____ Zip/Postal Code:_____**

4. **Home Phone: _____ Cell Phone: _____ Work: _____**
   May I leave a message? _____
   Email:_____

5. **SS#:_____**

6. **Age: _____ Birth date: _____ Gender: _____**

   Do you identify as transgender? _____

7. **Education (grade/degree completed, any post secondary): _____**

8. **Current Occupation: _____**

9. **Person to alert in the event of a medical emergency: _____**

   Address: _____

   Relationship to you: _____ Phone: _____

10. **Family Doctor: _____ Phone: _____**

11. **Relationship status (circle one): Single Married Partnered Separated Divorced Widowed**

How long? _____

12. **Spouse's/partner's name: _____ Phone: _____**

13. Children (gender, age): _____
_____

PRIMARY INSURANCE:

Company Name: _____Ins. ID#_____

Group Name: _____Group #_____Employer:_____

Subscriber's Name:_____ Relation:_____ Subscriber's DOB:_____

I certify to the best of my knowledge that all information provided is true and correct.

Name_____ Date:_____

Signature:
_____

14. ALLERGIES:
_____
_____
_____

15. Current Medications—Dose, Frequency, Date Last Taken

1._____
2._____
3._____
4._____
5._____
6._____
7._____
8._____

Recreational Drugs—Method, Frequency, Total # of Experiences, Last Date Used

___ Alcohol ___ Marijuana ___ Hallucinogens ___ Cocaine ___ Cigarettes ___ Caffiene
___ Opiates ___ Other _____

Please Elaborate:

_____
_____
_____
_____
_____

16. Medical Illnesses, Surgical Procedures, Head Injuries/Loss of Consciousness, Current and Past:

_____
_____
_____
_____
_____

17. Have you had previous psychological care or counseling? ☐ **Yes**
☐ **No**

If yes, please give the name of the clinician(s), the dates you saw them (e.g. Nov 2018), and the nature of the difficulty at that time.

_____
_____
_____
_____
_____

Were you formally diagnosed with any of the following:

Bipolar disorder	☐ Yes	☐ No	**Schizophrenia**	☐ Yes	☐ No	**Depression**	☐ Yes	☐ No
PTSD	☐ Yes	☐ No	**Anxiety**	☐ Yes	☐ No	**Alcohol abuse**	☐ Yes	☐ No
Other substance abuse	☐ Yes	☐ No	**Anger**	☐ Yes	☐ No	**Suicide**	☐ Yes	☐ No
Violence	☐ Yes	☐ No						

18. Have you been prescribed psychiatric medications in the past (e.g. antidepressants, antipsychotics, mood stabilizers, stimulants, tranquilizers)? If so, list each one with dose and describe their effects, note whether you felt them to be helpful.

_____
_____
_____
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19. Have you ever been hospitalized for a psychological difficulty? ☐ **Yes** ☐ **No**

Have you ever had feelings or thoughts that you didn't want to live? ☐ **Yes** ☐ **No**

* * * * * *

If YES, please answer the following. If NO, please skip to question 20 (on next page).

Do you currently feel that you don't want to live? ☐ ***Yes*** ☐ ***No***

How often do you have these thoughts?

_____

When was the last time you had thoughts of dying?

_____

Has anything happened recently to make you feel this way?

_____

On a scale of 1 to 10 (ten being strongest), how strong is your desire to kill yourself currently?

_____

Would anything make it better?

_____

Have you ever thought about how you would kill yourself?

_____

Is the method you would use readily available?

_____

Have you planned a time for this?

_____

Is there anything that would stop you from killing yourself?

_____

Do you feel hopeless and /or worthless?

_____

Have you ever tried to kill or harm yourself before?

_____

20. How would you rate your current sleeping habits? (Please circle)

Poor Unsatisfactory Satisfactory Good Very Good

Do you have:

-Difficulty falling asleep? ☐ **Yes** ☐ **No**
-Awakenings during the night? ☐ **Yes** ☐ **No**
-Poor or unrefreshing sleep? ☐ **Yes** ☐ **No**

If so, for how long have you been experiencing this problem(s)?

_____

21. Current Weight _____ Height _____

Are you happy with your weight? _____

Have you recently lost or gained weight? ☐ Yes

☐ No

Please describe any difficulties you experience with your appetite or eating patterns:

_____

_____

_____

22. Are you currently experiencing overwhelming sadness, grief, or depression? Please circle.

If yes, for how long? _____

23. Are you currently experiencing anxiety, or panic attacks? ☐ Yes

☐ No

If yes, for how long? _____

24. How many days per week do you drink alcohol? _____

How many drinks per night? _____

How often do you binge drink (4-5 drinks within a couple hours)? _____

25. How often do you use recreational drugs? _____

26. Have you ever had a dependency on alcohol or recreational drugs? ☐ Yes

☐ No

If yes, please explain the nature of dependency or abuse:

_____

_____

27. Have you ever or do you now have a history of prescription drug dependency or abuse? ☐ Yes

☐ No

If yes, which drug? Please explain the nature of dependency or abuse:

_____

_____

28. Females: Are you or could you be pregnant? _____

If applicable, what form of BC do you use? _____

29. Do you have any blood relative/family member(s) that have been diagnosed with or treated for:
Please include collateral relatives (ie. Cousins, grandparents, aunts, uncles, etc..)

Bipolar disorder	☐ Yes	☐ No	**Schizophrenia**	☐ Yes	☐ No	**Depression**	☐ Yes	☐ No
PTSD	☐ Yes	☐ No	**Anxiety**	☐ Yes	☐ No	**Alcohol abuse**	☐ Yes	☐ No
Other substance abuse	☐ Yes	☐ No	**Anger**	☐ Yes	☐ No	**Suicide**	☐ Yes	☐ No
Violence	☐ Yes	☐ No						

If yes, who had what problems?

_____

_____

_____

_____

_____

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_____

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_____

Has any family member been treated with a psychiatric medication? ☐ **Yes**
☐ **No**

If yes, who was treated, what medications, and how effective was the treatment?

_____

_____

_____

_____

30. In your own words, what is the nature of the concern that you wish to address in therapy? Feel free to describe this in as much or as little detail as you wish. What do you consider some of your strengths? Weaknesses?

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31. Please list with dates any significant trauma you have experienced: violence—physical, sexual, emotional; abuse; natural occurrences; etc.

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