Laurie Mendiones MFT Date_____

Client Intake Form

.Please print out this form and bring it to your first session.

Name: _____
(Last) (First) (MI)

Name of parent/guardian (if you are a minor):

_____
(Last) (First) (MI)

Birth Date: _____ /_____ /_____ Age: _____ Gender: ☐ Male ☐ Female ☐ Transgender

Marital Status:
☐ Never Married ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Are you currently in a romantic relationship? ☐Yes ☐No How long?_____

On a scale of 1-10 (10=great), how would you rate the quality of your relationship? ____

Sexual Preference: Men Women Both

Number of Children: _____ Ages: _____

Local Address:

_____
(Street and Number)
_____
(City) (State) (Zip)

Home Phone: _____ May we leave a msg? ☐Yes ☐No

Cell Phone: _____ May we leave a msg? ☐Yes ☐No

E-mail: _____ May we email you? ☐Yes ☐No
*Please be aware that email might not be confidential.

Person to contact in case of an emergency:

_____ _____ _____
(Name) (Relationship to client) (Phone)

Referred by: _____

What brought you in to see me today?

Have you had previous psychotherapy? ☐No ☐Yes Reason_____

Are you currently taking prescribed psychiatric medications (antidepressants or others)?

☐Yes ☐No If Yes, please list: _____

If No, have you been previously prescribed psychiatric medication? ☐Yes ☐No

If Yes, please list: _____

Are you hopeful about your future? ☐Yes ☐No

Are you having current suicidal thoughts? ☐ Frequently ☐ Sometimes ☐ Rarely ☐ Never

Have you had suicidal thoughts in the past? ☐ Frequently ☐ Sometimes ☐ Rarely
☐ Never When?_____

Are you having current homicidal thoughts? ☐Yes ☐No Previously? ☐Yes ☐No

HEALTH AND SOCIAL INFORMATION

1. How is your physical health at present? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

2. Please list any chronic health problems or concerns (e.g. asthma, hypertension, diabetes, headaches, stomach pain, seizures, etc.):

_____

Any Allergies? ☐ No ☐ Yes List:_____

Medications:_____

_____

3. Are you having any problems with your sleep habits? ☐ No ☐ Yes Hrs/night_____
If yes, check where applicable:

☐ Sleeping too little ☐ Sleeping too much ☐ Can't fall asleep ☐ Can't stay asleep

4. How many times per week do you exercise? _____ For how long? _____

5. Are you having any difficulty with appetite or eating habits? ☐ No ☐ Yes
If yes, check where applicable: ☐ Eating less ☐ Eating more ☐ Binging ☐ Purging
Have you experienced significant weight change in the last 2 months? ☐ No ☐ Yes

6. Do you regularly use alcohol? ☐ No ☐ Yes If yes, what is your frequency?
☐ once a month ☐ once a week ☐ daily ☐ daily, 3 or more ☐ intoxicated daily

7. How often do you engage recreational drug use? ☐ Daily ☐ Weekly ☐ Monthly
What drugs_____ ☐ Rarely ☐ Never

8. Do you smoke? ☐ No ☐ Yes How many per day?_____

9. Do you drink caffeinated drinks? ☐ No ☐ Yes
# of sodas per day_____ cups of coffee per day_____

10. In the last year, have you experienced any significant life changes or stressors:

_____ _____

_____ _____

<u>Are you now experiencing</u>: *Rating Scale 1-10 (10 =worst)

Depressed mood or sadness	yes	no
Irritability/Anger	yes	no
Mood Swings	yes	no
Rapid Speech	yes	no
Racing Thoughts	yes	no
Anxiety	yes	no
Constant Worry	yes	no
Panic Attacks	yes	no
Phobias	yes	no
Sleep Disturbances	yes	no
Hallucinations	yes	no
Paranoia	yes	no
Poor Concentration	yes	no
Alcohol/Substance Abuse	yes	no
Frequent Body Complaints (e.g., headaches)	yes	no
Eating Disorder	yes	no
Body Image Problems	yes	no
Repetitive Thoughts (e.g., Obsessions)	yes	no
Repetitive Behaviors (e.g., counting)	yes	no
Poor Impulse Control (e.g., ↑ spending)	yes	no
Self Mutilation	yes	no
Sexual Abuse	yes	no
Physical Abuse	yes	no

Emotional Abuse yes no

*Note: use rating scale with a "yes" response only.

OCCUPATIONAL INFORMATION: Are you employed? ☐ No ☐ Yes
If yes, who is your current employer/position? _____

If yes, are you happy at your current position? _____

Please list any work-related stressors, if any: _____

Are you currently in the military? ☐ No ☐ Yes Previously? ☐ No ☐ Yes

Highest level of education:_____

Any legal concerns? ☐ No ☐ Yes_____ Financial concerns? ☐ No ☐ Yes_____

RELIGIOUS/SPIRITUAL INFORMATION:
Do you consider yourself to be religious? ☐ No ☐ Yes
If yes, what is your faith? _____

If no, do you consider yourself to be spiritual? ☐ No ☐ Yes

FAMILY HISTORY:
Are your parents: ☐ still together ☐ divorced, when_____ ☐ remarried ☐ unmarried
☐ deceased, if yes whom_____ age at death_____
Number of siblings:_____ Ages:_____
Do you have good family support? ☐ No ☐ Yes By whom?_____

FAMILY MENTAL HEALTH HISTORY:
Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (circle any that apply and list family member, e.g., Sibling, Parent, Uncle, etc.):

Difficulty		**Family Member**
Depression	yes/no	
Bipolar Disorder	yes/no	
Anxiety Disorders	yes/no	
Panic Attacks	yes/no	
Schizophrenia	yes/no	
Alcohol/Substance Abuse	yes/no	
Eating Disorders	yes/no	
Learning Disabilities	yes/no	
Trauma History	yes/no	
Suicide Attempts	yes/no	
Psychiatric Hospitalizations	yes/no	

OTHER INFORMATION:
What do you consider to be your strengths?

What do you like most about yourself?

Was there a significant person in your life? Someone who inspired you in some way?

What are effective coping strategies do you use when stressed?

What are your overall goals for therapy?

What do you feel you need work on first?