Dr Eileen R. Borris

PRIVATE & CONFIDENTIAL - CLIENT INTAKE FORM

Information provided here will be treated with the same degree of confidentiality as anything you share with me when we meet. Please feel free to skip questions you prefer not to answer. In gray shaded areas, please select appropriate responses from the options listed. Many thanks & WELCOME!

Name____ **Today's date** ________
First Last MI

Birth date _______-______-__________ **Age**__________ **Gender** _________________________

Address____ **City**______________________

State____ **Zip**________

Marital Status: ____Married ____Single ____In Relationship ____Divorced ____Widowed ____Separated

Please indicate preferred contact with an (X): ( ) Cell (______)____________________ ( ) Home (___)_____

( ) Work (______)______________________________ ***May I leave messages at all of these?*** ***Y / N***

Email: ____(***confidentiality not guaranteed electronically)***

Billing/Responsible Party (if Different from Above): **Name :** _____________________________________

Address____**City**__________________

________**_State**___ **Zip**__________

Preferred Method of Payment: **( ) Cash ( ) Check** ***(Please note, I do not accept credit card at this time.)***

Contact person in case of emergency: ____**Relationship**________________

Telephone (______) ____________________________ **Other Telephone** (______) ____________________________

Do I have permission to contact this person in the event of an emergency?* **Y / N *Please initial here*: _____________

Briefly, please explain what brings you in today?_______________________________________
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____

When did this issue first present, and why get help NOW?_______________________________________
____
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____

Have you previously been in therapy/Counseling? Briefly describe the reason which brought you to therapy, when you went, and with whom.

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____
____
____
____

How strongly do you want treatment? Very strongly! Somewhat I could do without it, if necessary I really don't want help

Sleep (past month): ☐ No problems ☐ Too Much Sleep ☐ Not Enough Sleep / # Hours per night: ___ # Hours per day: ___

☐ **Trouble falling asleep due to:** ☐ pain ☐ thoughts ☐ excessive energy ☐ environment (e.g., noise/light) ☐ Don't Know

☐ **Trouble staying asleep due to:** ☐ pain ☐ urinary frequency ☐ restlessness ☐ environment (e.g., noise/light) ☐ Don't Know

☐ **Early awakening due to:** ☐ pain ☐ urinary frequency ☐ restlessness ☐ environment (e.g., noise/light) ☐ Don't Know

Do you experience nightmares? Y / N If yes, how often? ________________________________

Have you ever gone days with little or no sleep yet felt energized and active still? Y / N

Do you engage in impulsive, high-risk behaviors? Y / N If yes, please list: ____________________
____
____
____

<u>Please check box if you have experienced symptoms below over past two weeks:</u>

O Frequent sadness/tearfulness O Loss of interest in previously enjoyed activities O Guilt/Regrets
O Fatigue/loss of energy O Difficulties concentrating/decision-making O Anxiety/worry
O Change in weight/appetite O Feelings of Loneliness/Emptiness O Sexual Dysfunction
O Thoughts of death/dying O Feelings of worthlessness O Irritability
O Feelings of hopelessness O Work/school/family problems O Relationship problems
O Social Withdrawal O Hearing/seeing things that aren't there O Mood swings

Family Data

Where were you born? ________________________ And raised? ___________________________

Did your biological parents raise you? **Y / N** If No, who did and during what years?______________________

Is your father still living? **Y / N** If yes, how is/was your relationship with him? Excellent Good Fair Poor

His occupation: ______________________________________ How often do you talk/meet? __________

Describe his personality & attitude toward you:____

If deceased, state cause & year/age at time of death: __________________________________

Is your mother still living? **Y / N** If yes, how is/was your relationship with her? Excellent Good Fair Poor

Occupation: ____ How often do you talk/meet? __________

Describe her personality & attitude toward you:____

If deceased, state cause & year/age at time of death: __________________________________

Are your biological parents still married? **Y / N** If not, how old were you when they divorced? ____________

If you have a step-parent, how old were you when your natural parent(s) remarried? _____________

How is your relationship with your step-parent(s): **Great** **Good & Bad** **Not bad** **Poor**

If you have siblings, list names, ages, gender, jobs, & your relationship with each: ________________________

How would you describe your childhood home? Please comment on compatibility between parents and between parents and children: ____

Were you able to confide in your parents? **Y / N** Siblings? **Y / N** If no, why? __________________________

What forms of discipline were used in your home?____

Please briefly describe your family when you were growing up:
____

Please list any events from your childhood / or adulthood that have had a profound effect on your life:
____

Highest grade/Degree completed? ____________ Where? ____________

How many hours a week are you employed? ____________

How often do you spend time with others?____________

How many Children do you have?____________ Do they all live with you?____________

Describe any areas of conflict with your children and/or spouse:
____

Relationship History

How satisfied are you with your current relationship <u>status</u> (e.g., single, married, divorced)? **__ Very __ Somewhat __Not**

Are you currently in a committed romantic relationship? **Y / N** **If yes, h**ow long have you known your partner? ______________

Spouse/Partner's personality: ____

In what areas are you compatible? ____

In what areas are you incompatible? ____

Describe areas of conflict with your partner: ____
____
____

If married, how long were you engaged? ______________________ When were you married? _______

Current Spouse's/Partner's Name: _________________________________ Age: ___ Occupation: _________

How is your relationship with your in-laws: **Great** **Good & Bad** **Not bad** **Not well**

Were you married before? **Y / N** If yes, please list year(s) of prior marriage, divorce, & reason(s) for divorce:
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____
____

Do you have children? **Y / N** If yes, please list names, ages, sex, and brief description of each child's personality. Indicate if either is from a previous marriage.______________________________
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Describe any areas of conflict with your children: ____
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____

Please give me the name and possibly the address of the person who referred you to me.____
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____

Mental Health History

Have you been in therapy before? (Please list all persons seen, dates, for what, for how long each time, & whether it helped): ____

____

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____

____

Have you ever been hospitalized for mental illness? **Y / N** If yes, for what, when, where, and for how long?

____

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____

____

Please list past events that have profoundly affected you (e.g., serious car accidents; violence): ____________

____

____

If any, do you feel you relive any of these, think of them when you don't want to, or avoid reminders of them? (such as flashbacks/nightmares)? **Y / N** **If Yes,** please explain: ______________________________

____

Is there a history of family mental illness (e.g., depression, suicide, substance abuse, schizophrenia)? **Y / N / DK**

If yes, please list issue(s) & whether treatment was received:______________________________________

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____

Do you or have you taken medications for emotional/behavioral issues (e.g., anxiety, depression, sleep)? Y /N

If yes, Please list medication, indicate time of use and whether you benefitted: ______________________

____

Family Physician / Name: ____**Phone** (______) ________________

Psychiatrist, if applicable / Name: ____**Phone** (______) ________________

Release of Information: "I give Dr. Borris permission to contact these doctors regarding health issues relevant to my ongoing treatment, as necessary. I understand that this information will remain confidential."

____ (**Signature, Date**)

Substance Use & Legal History

Do you smoke cigarettes? **___ Yes ___ No** If no, h**ave you ever smoked cigarettes & stopped? ___ Yes ___ No**

If Yes to either, a) **How many cigarettes per day?** ___________

b) For h**ow many years?** _____________

c) **If you quit, when?** ________ How did you quit? _________________________ ________________

Please Indicate amount and Frequency of any Substance you use or have used below:

	Current	Past		Current	Past
Alcohol			Narcotics / Pain		
Tobacco			Diet Pills		
Caffeine (tea, coffee, Soda)			Sleeping pills		
Cocaine			Anti-Anxiety Meds		
Marijuana			Anti-Depressants		
Heroine			Other Illegal Drug		

Have you ever had a problem with (or received treatment for) alcohol or other drug use? Y /N
If yes, please explain:____ ______________
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____

Have you ever served in the military? **Y / N** Have you ever been arrested? **Y /N** If yes, were you convicted? **Y /N**

If convicted, what was the charge? ____Have you ever served jail time? **Y / N**

Are you currently or have you ever been involved in a lawsuit? **Y /N** If yes, please explain: _______________
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____

Timing

How stressful has your life been **during the past 6 months? *(Circle one)***

I've had NO stress **Much less stressful than usual** **Less stressful than usual**

Average level of stress **More stressful than usual** **Much more stressful than usual**

Please circle Yes or No to indicate (current) <u>greater than usual stress</u> in the following areas:

- Work: **Yes No**
- Health: **Yes No**
- Relationship with spouse/significant other: **Yes No**
- Activities related to your children: **Yes No**
- Activities related to your parents: **Yes No**
- Legal/financial trouble: **Yes No**
- School: **Yes No**
- Moving: **Yes No**
- Other:____

Briefly explain any items above to which you responded "Yes," unless covered elsewhere:__________

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Are you planning major life changes (i.e., new job, moving, relationship, etc.) in the next 6 months? **Y / N**

If yes, please specify: ____

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AUTHORIZATION TO RELEASE / OBTAIN INFORMATION

I, (parent/guardian if patient is a minor) ________________________________, hereby authorize

Dr. Eileen Borris to obtain information from and/or release information to:

____

____

____

Regarding Patient:______________________________________

Date of Birth:_____________

Portion of record to be released:
( ) All
( ) Diagnostic Evaluation
( ) Summary of Contact with Client
( ) Verbal Contact
( ) Diagnostic Test Reports

( ) other: specify_______
____
____

I understand why this information is needed and I am satisfied that it will be held confidential.

Photocopies of this form will be considered as valid as the original.

This authorization will remain in effect until revoked by me in writing.

Signed: _____________________________

Date: _____________________________