## DANA ANDERSON, LMFT

## CLIENT INTAKE FORM

Please provide the following information. Leave blank any question you would like to discuss with the counselor or would rather not answer. The confidentiality of these responses is the same as the confidentiality of the information discussed during out sessions.

Name: ________________________________________

Name of Parent/Guardian (for minor clients only)

___________________________________________

Date of Birth: ____/______/_______ Gender: ________

Marital Status: ____ Single ____ Married _____ Separated _____ Divorced

___ In Committed Relationship ____ Widowed

Spouse/Partner's Name: _________________________

Local Address: ___________________________________________________________
(Street and Number)

____________________________________________________________
(City) (State) (Zip)

Home Phone: ( ) ____________________ May I leave a message? __Yes ___No

Cell Phone: ( )______________________ May I leave a message? __ Yes ___ No

E-mail: _______________________________________May we email you? □ Yes □ No
*Please be aware that email might not be confidential.

Referred by: ____________________________________________________________

How did you hear about me?:_______________________________

Are you currently receiving psychiatric services, professional counseling or psychotherapy elsewhere? □ Yes □ No

Have you had previous psychotherapy? □No □Yes

Previous therapist's name ______________________________________

Are you currently taking prescribed psychiatric medication (antidepressants or others)?
□Yes □No If Yes, please list date(s) taken, name, dosage, and frequency of dosage:

____________________________________________________________________________

____________________________________________________________________________

If no, have you been previously prescribed psychiatric medication?

□Yes □No If Yes, please list date(s) taken, name, dosage, and frequency of dosage:

____________________________________________________________________________

____________________________________________________________________________

**HEALTH AND SOCIAL INFORMATION**

1. How is your physical health at present? (please circle)
Poor Unsatisfactory Satisfactory Good Very good

2. Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.):

____________________________________________________________________________

____________________________________________________________________________

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

□ Sleeping too little □ Sleeping too much □ Poor quality sleep □ Disturbing dreams

□ Other ___________________________

4. How many times per week do you exercise? ___________
Approximately how long each time? ___________

5. Are you having any difficulty with appetite or eating habits? □ No □ Yes

If yes, check where applicable: □ Eating less □ Eating more □ Binging □ Restricting

Have you experienced significant weight change in the last 2 months? □ No □ Yes

6. Do you regularly use alcohol? □ No □ Yes
In a typical month, how often do you have 4 or more drinks in a 24-hour period? ___________

7. How often do you engage in recreational drug use?
□ Daily □ Weekly □ Monthly □ Rarely □ Never

8. Have you had suicidal thoughts recently? □ Frequently □ Sometimes □ Rarely □ Never

Have you had them in the past? □ Frequently □ Sometimes □ Rarely □ Never

9. Are you currently in a romantic relationship? □ No □ Yes

If yes, how long have you been in this relationship? ___________________

On a scale of 1-10, how would you rate the quality of your current relationship? _______

10. In the last year, have you experienced any significant life changes or stressors? If so, please explain?

________________________________________________________________________

________________________________________________________________________

**Have you ever experienced:**
Extreme depressed mood: □ No □ Yes

Wild Mood Swings: □ No □ Yes

Rapid Speech: □ No □ Yes

Extreme Anxiety: □ No □ Yes

Panic Attacks: □ No □ Yes

Phobias: □ No □ Yes

Sleep Disturbances: □ No □ Yes

Hallucinations: □ No □ Yes

Unexplained losses of time: □ No □ Yes

Unexplained memory lapses: □ No □ Yes

Alcohol/Substance Abuse: □ No □ Yes

Frequent Body Complaints: □ No □ Yes

Eating Disorder: □ No □ Yes

Body Image Problems: □ No □ Yes

Repetitive Thoughts (e.g., Obsessions) : □ No □ Yes

Repetitive Behaviors (e.g., Frequent Checking, Hand-Washing) : □ No □ Yes

Homicidal Thoughts: □ No □ Yes

Suicide Attempt: □ No □ Yes

**OCCUPATIONAL INFORMATION:**
Are you currently 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: _____________________________________

**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 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: □ No □ Yes ____________________________________________
Bipolar Disorder: □ No □ Yes ____________________________________________
Anxiety Disorders: □ No □ Yes ____________________________________________
Panic Attacks: □ No □ Yes ____________________________________________
Schizophrenia: □ No □ Yes ____________________________________________
Alcohol/Substance Abuse: □ No □ Yes _________________________________________
Eating Disorders: □ No □ Yes ____________________________________________
Learning Disabilities: □ No □ Yes ____________________________________________
Trauma History: □ No □ Yes ____________________________________________
Suicide Attempts: □ No □ Yes ____________________________________________

**OTHER INFORMATION:**

What do you consider to be your strengths?

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

______________________________________________________________

What do you like most about yourself?

_______________________________________________________________________________

_______________________________________________________________________________

______________________________________________________________________

What are effective coping strategies that you've learned?

_______________________________________________________________________________

_______________________________________________________________________________

_____________________________________________________

What are your goals for therapy?

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________