CLIENT INTAKE FORM

DeLIGHTeD Life Counseling

Please answer the following questions to the best of your abilities. These questions are to help the therapist with the therapy process. This information is held to the same standards of confidentiality as our therapy.

Name:_____
(Last) (Given) (Preferred) (Middle Initial)

Birth date: _____/_____/_____ Age:_____ Gender: Male Female Transgender

Marital status: Never married Partnered Married Separated Divorced Widowed

Number of children: _____ Ages:_____

Current address: _____
(city) (state) (zip)

Home phone:_____ May we leave a message? Yes No

Cell/other: _____ May we leave a message? Yes No

Work phone: _____ May we leave a message? Yes No

Email:_____ May we email you?* Yes No

*NOTE: Emails may not be confidential

Who may we contact in case of an emergency: _____ Telephone number_____

Referred by: Insurance company Internet search Word of mouth Advertisement Other:_____

Primary insurance co & identification number: _____

Insurance subscriber name and date of birth: _____

Secondary insurance identification number: _____

Insurance subscriber name and date of birth:_____

Are you currently receiving psychological services, professional counseling, psychiatric services, or any other mental health services? Yes No

Reason for change:_____

Are you currently taking any psychiatric prescription medication? Yes No

If yes, please list:_____

Have you been prescribed psychiatric prescription medication in the past? Yes No

If yes, please list:_____

Have you been psychiatrically hospitalized in the past? Yes No

If yes, please list dates and locations:_____

General Health Information

Please provide the name, address and telephone number for your primary care physician: _____

_____

_____

How is your physical health at the present time? Poor Unsatisfactory Satisfactory Good Very good

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

_____

_____

Are you on any medication for physical/medical issues? Yes No
If yes, please list:_____

Are you having any problems with your sleep habits? Yes No
If yes, circle those that apply:
Sleep too much Sleep too little Poor quality Disturbing dreams Other:_____

Are there any changes or difficulties with your eating habits? Yes No
If yes, circle those that apply:
Eating less Eating more Bingeing Restricting Other:_____

Have you experienced a weight change in the last two months? Yes No

Do you exercise regularly? Yes No
If yes, how many days per week do you exercise? _____ How many minutes/hours per session: _____

Do you consume alcohol regularly? Yes No
In one month, how many times do you have four or more drinks in a 24-hour period?_____

How often do you engage in recreational drug use? Daily Weekly Monthly Rarely Never
What kinds of recreational drugs do you use: _____

Are you currently in a romantic relationship? Yes No

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

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

In the last year, have you had any major life changes (e.g. new job, moving, illness, relationship change, etc.)?

_____

_____

Quick Check

Check the issues below that apply to you.

Depressed mood	Panic Attacks	Memory Lapse	Relationship Problems
Mood Swings	Phobias	Trouble planning	Hallucinations
Rapid Speech	Repetitive Behaviors	Sleep Disturbance	Eating difficulties
Suicidal Thoughts	Anxiety	Time loss	Body Complaints
Homicidal thoughts	Excessive Worry	Alcohol/Drug abuse	Traumatic Event

Have you felt depressed recently? Yes No

If yes, for how long?_____

Have you had any suicidal thoughts recently? Yes No

If yes, how often? Frequently Sometimes Rarely

Have you ever had suicidal thoughts in your past? Yes No

If yes, how long ago?_____

How often did you have these thoughts? Frequently Sometimes Rarely

Family Mental Health History

The following is to provide information about your family history. Please mark each as yes or no. If yes, please indicate the family member affected.

Depression	Yes	No	_____
Suicide	Yes	No	_____
Anxiety Disorders	Yes	No	_____
Bipolar Disorder	Yes	No	_____
Panic Attacks	Yes	No	_____
Alcohol/Substance Abuse	Yes	No	_____
Eating Disorder	Yes	No	_____
Trauma History	Yes	No	_____
Domestic Violence	Yes	No	_____
Sexual Abuse	Yes	No	_____
Obesity	Yes	No	_____
Obsessive Compulsive Behavior	Yes	No	_____
Schizophrenia	Yes	No	_____

Religious/Spiritual Information

Do you practice a religion? Yes No

If yes, what is your faith? _____

Occupational Information

Are you currently employed? Yes No

If yes, who is your employer?_____

What is your position?_____

Are you happy in your current position? Yes No

Does your work make you stressed? Yes No

If yes, what are your work-related stressors?_____

Other Information

List your strengths and what you like most about yourself:_____

_____

_____

List areas you feel you need to develop _____

_____

_____

What are some ways you cope with life obstacles and stress?_____

_____

_____

What are your goals for therapy/what would you like to accomplish?

_____

_____

_____

By signing below, I am acknowledging that I have chosen to receive mental health services in the form of evaluation and psychotherapy from DeLIGHTeD Life Counseling. My decision is voluntary and I understand that I may terminate these services at any time. I also understand that during the course of treatment I may need to discuss material of an upsetting nature in order to resolve my problems. Further, I understand it cannot be guaranteed that I will feel better after completion of treatment.

_____ _____

Signature Date