Janice Terry Counseling Services

Scott Grizzle, LPC Intern

CLIENT INTAKE FORM

Please provide the following information for our records. Leave blank any question you would rather not answer, or would prefer to discuss with your therapist. Information you provide here is held to the same standards of confidentiality as our therapy.

PERSONAL INFORMATION:

Client Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____ Age: _____

Cell Phone: _____ Home Phone: _____

Email: _____

Emergency Contact: (Name): _____

(Phone #): _____ (Relationship): _____

If client is a minor, legal guardian's information:

Name: _____

Address: _____

Phone: _____ Email: _____

CHIEF COMPLAINT: (Please describe your reason for seeking counseling)

_____

_____

_____

_____

_____

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TREATMENT HISTORY:

Are you ***currently*** receiving psychiatric services, professional counseling or psychotherapy elsewhere? ( ) yes ( ) no If yes, provide name and phone # of psychiatrist or counselor:

_____

Have you ***previously*** received psychiatric services, professional counseling or psychotherapy elsewhere? ( ) yes ( ) no If yes, provide name and phone # of psychiatrist, counselor, or organization:

_____

Are you currently taking prescribed psychiatric medication (antidepressants or others)?
( ) yes ( ) no

If yes, please list: _____

Prescribed by: _____

HEALTH AND SOCIAL INFORMATION:

Do you currently have a primary physician? ( ) yes ( ) no

If yes, who is it? _____
Are you currently seeing more than one medical health specialist? ( ) yes ( ) no

If yes, please list: _____

When was your last physical? _____

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

_____

Are you currently on medication to manage a physical health concern? If yes, please list medication, condition, and dosage:

_____
_____
_____

Are you having any problems with your sleep habits? ( ) yes ( ) no

If yes, check where applicable:
( ) Sleeping too little ( ) Sleeping too much ( ) Poor quality sleep
( ) Disturbing dreams ( ) other _____

How many times per week do you exercise? _____

Approximately how long each time? _____

Are you having any difficulty with appetite or eating habits? ( ) no ( ) yes

If yes, check where applicable: ( ) Eating less ( ) Eating more ( ) Bingeing
( ) Restricting

Have you experienced significant weight change in the last 2 months? ( ) no ( ) yes

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?
_____

How often do you engage in recreational drug use? ( ) daily ( ) weekly ( ) monthly ( ) rarely ( ) never List drugs:
_____

Do you smoke cigarettes or use other tobacco products? ( ) yes ( ) no

Have you had suicidal thoughts recently?
( ) frequently ( ) sometimes ( ) rarely ( ) never

Have you had them in the past?
( ) frequently ( ) sometimes ( ) rarely ( ) never

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 (10 being the highest quality), how would you rate your current relationship? _____

In the last year, have you experienced any significant life changes or stressors? If yes, please explain:

_____

_____

Have you ever experienced any of the following? If yes, rate the severity of the symptom from 1-10, with 1 being low and 10 being the highest level of severity.

	(If yes, rate from 1-10)
Extreme depressed mood	Yes / No
Dramatic mood swings	Yes / No
Rapid speech	Yes / No
Extreme anxiety	Yes / No
Panic attacks	Yes / No
Phobias	Yes / No
Hallucinations	Yes / No
Unexplained losses of time	Yes / No
Unexplained memory lapses	Yes / No
Alcohol/substance abuse	Yes / No
Frequent body complaints	Yes / No
Eating disorder	Yes / No
Body image problems	Yes / No
Repetitive thoughts (e.g. obsessions)	Yes / No
Repetitive behaviors (e.g. frequent checking, hand washing, etc)	Yes / No
Homicidal thoughts	Yes / No
Suicidal attempts	Yes / No If yes, when?

Counselor use only:

OCCUPATIONAL INFORMATION:

Are you currently employed? ( ) no ( ) yes

If yes, who is your currently employer/position? _____

If yes, are you happy with 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

Do you desire for spirituality to be a component of therapy? ( ) no ( ) yes

FAMILY MENTAL HEALTH HISTORY:

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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	Yes / No	Family member
Depression	Yes / No	
Bipolar disorder	Yes / No	
Anxiety disorder	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	
Chronic illness	Yes / No	
Other:	Yes / No	

GOALS FOR THERAPY:

(Please list briefly what you want to accomplish through therapy.)

_____

_____

_____

PAYMENT INFORMATION:

I understand that counseling provided by Janice Terry Counseling Services is an out of network service for insurance purposes. (This means that we do not file for payment with your insurance company.) I understand that payment for services rendered are due at the beginning of each session payable by cash, check or credit card. Failure to provide payment on the second occurrence will result in the postponement of appointments until the account is current. A $25 service charge will be applied to returned checks for insufficient funds. Cash or credit card will be required after one returned check.

☐ Check if you are a legal guardian giving consent for counseling of a minor child.

_____
Client Name or Legal Guardian (Please Print)

_____ _____
Signature Date