Hope for Healthy Families Counseling Center
8788 Elk Grove Blvd, Bldg 1, Suite L
Elk Grove, California 95624
Phone (916) 686-9209 Fax (916) 686-9209

CLIENT INTAKE FORM

Please provide the following information for our records. Leave blank any question you would rather not answer. Information you provide here is held to the same standards of confidentiality as our therapy. Please fill out this form and bring it to your first session or allow yourself thirty minutes prior to your appointment to complete the form in the office.

Name: _____

(Last) (First) (Middle Initial)

Local Address:

_____

(Street and Number)

_____

(City) (State) (Zip)

Home Phone: ( ) _____ May we leave a message? □ Yes □ No

Cell/Msg. Phone: ( ) _____ May we leave a message? □ Yes □ No

Birth Date: _____ /_____ /_____ Age: _____ Gender: □ Male □ Female

Marital Status: □ Never Married □ Partnered □ Married □ Separated

□ Divorced □ Widowed

Number of Children: _____ ____ Girl(s) ____Boy(s)

E-mail: _____ May we email you? □ Yes □ No

*Please be aware that email might not be confidential.

Referred by: _____

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

Have you had previous psychotherapy? □ No If Yes, previous therapist's name:

_____

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

□ Yes □ No If yes, please list: _____ _____

_____ _____ _____

If no, have you been previously prescribed any medication? □ Yes □ No

If yes, please list: _____ _____ _____

_____ _____ _____ _____

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? _____ 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 □ Restricting

Have you experienced significant weight change in the last 2 months?

□ No □ Yes

6. Do you regularly use alcohol? □ No □ Yes

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:

_____

Have you ever experienced any of the following?

Extreme depressed mood: □ No □ Yes Extreme 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

Homicidal Thoughts: □ No □ Yes Suicide Attempt: □ No □ Yes

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

Repetitive Thoughts (e.g., Obsessions): □ 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

*Leave this question blank if you would rather not answer.

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 applies 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?

_____

_____

_____

_____

Your signature below indicates receipt of a copy of HIPAA:

_____ _____

Signature Date