Hope for Healthy Families Counseling Center
9075 Elk Grove Blvd., Suite 220A
Elk Grove, CA 95624
Phone (916) 686-9209
info@hopeforhealthyfamilies.org

CLIENT INTAKE FORM

Please provide the following information for our records. Leave blank any question you would rather not answer. The 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? □ Yes □ 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 <u>any</u> 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, Handwashing): ▫ 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