Resonant Healing

Psychotherapy Client Intake Form

Thank you for providing the information and answers to the questions contained in this form. Please bring this completed form to your first session. The information that you provide here is protected as confidential material.

Name: _____
(Last) (First) (Middle Initial)

Name of parent/guardian (if you are a minor):

_____
(Last) (First) (Middle Initial)

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

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

Number of Children: _____

Local Address: _____
(Street and Number)

_____
(City) (State) (Zip)

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

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

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

Referred by: _____

Are you currently receiving any mental health services (psychotherapy, counseling, psychiatric)? □ Yes □ No

Have you had previous psychotherapy?
□No □Yes, at 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 psychiatric medication?
□Yes □No If Yes, please list: _____

List all current prescription medicine you are taking: _____

_____

List all supplements you are currently taking: _____

_____

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 □ Other _____

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

Which drug(s) _____

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 experiencing overwhelming sadness, grief or depression?
□ No □ Yes

If yes, for how long? _____

10. Are you experiencing anxiety, panic attacks or have any phobias? □ No □ Yes

If yes when did you first have this experience? _____

11. 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? _____

12. In the last year, have you experienced any significant life changes or stressors? __
_____

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 consider to be your weaknesses? _____

_____

_____

What do you like most about yourself? _____

_____

_____

What are effective coping strategies that you've learned? _____

_____

_____

What do you want to accomplish by your work in therapy? _____

_____

_____