CLIENT INFORMATION PACKAGE

(Please print)

Patient's Last Name ___________________ First _________________ Middle _____________

Birth Date ________________ Age ______ Sex _________

Street Address __________________________ City ____________ State _____ Zip Code ______

Home Phone ______________________ Mobile Phone ________________________

E-Mail Address __________________________

Please indicate preference for appointment reminders: Text ___ Call ___ E-mail ___

Marital Status: (check one)

Single ____ Married ____ Divorced ____ Separated _____ Widow____ Partner ____

Primary Care Physician __________________________ Phone _________________________

How were you referred to our office? (Please check all that apply)

Family/Friend ___ Psychology Today ___ Theravive ___ Church ___ Online ___ Google ___

In Case of Emergency

Name of local friend or relative ___________________________ Phone __________________

Signature

The above information is true to the best of my knowledge. I understand that I am financially responsible for any and all fees. I also authorize JM Counseling to obtain information from my Primary Care Physician or the person listed as an emergency contact, if necessary.

____ ____________________

Patient/Guardian Signature Date

INTAKE FORM

Please fill in as completely as possible: Date: ___________
Name: ____________________________________

Ethnicity:
African American Asian Caucasian Hispanic Native American Pacific Islander Other: ______

Explain the problem for which you are being seen today:
____

____

MOOD SYMPTOMS:
I am currently feeling: Happy Sad Mad Scared Confused Other: _________________
Please rate your mood on average over the last two weeks: (0 = Life not worth living 10 = happy)
0 1 2 3 4 5 6 7 8 9 10
Current suicidal thoughts: No Yes Explain: ____
Past suicidal thoughts or attempts: No Yes Explain:____
Please answer the following, taking into consideration patient's age/personality, based on the last 2 weeks:
Sleep Pattern (circle all that apply)
Average (7-8 hrs.) Can't fall asleep Can't stay sleep Awaken early morning Sleeping more than usual
Do you enjoy things: As much as ever Not as much as ever Not at all
I feel that most things are my fault True False
I often feel worthless True False
My energy is low often True False
My concentration is poor True False
I am hopeful about my future True False
My appetite is: Minimal Average Excessive
My weight has changed during this period: No Yes Explain: ____________________________________
I move: Slower than average Faster than average Average speed
I have **extremely** high (for no apparent reason) moods that others notice: Always Sometimes Never
These **excessively** high moods occur ________ times per year.
These **excessively** high moods last _________hours/days.
During these markedly elevated moods: (please do not complete this section if you marked high moods never)
1. I feel grandiose (special, very self confident, feel like I can do extraordinary things) Yes No N/A
2. I am irritable (Snapping at others for no reason, starting fights) Yes No N/A
3. People have thought I was using drugs when I wasn't Yes No N/A
4. I start many projects without completing them Yes No N/A
5. I get distracted easily and don't finish what I start Yes No N/A
6. I don't need to sleep much Yes No N/A
7. I have racing thoughts which I cannot control Yes No N/A

8. I dominate conversations and talk excessively	Yes	No	N/A
9. I have excessive energy	Yes	No	N/A
10. I have injured/cut myself	Yes	No	N/A
11. I engage in reckless behaviors	Yes	No	N/A

INTAKE FORM

Circle all that apply: Increased libido Shopping sprees Gambling Reckless driving
Stealing Alcohol or drugs Fighting Other ________________

I have been hospitalized for depression, mania or anxiety	True	False
I have heard voices when nobody was there	True	False
I have seen things that others say are not there	True	False

I have sudden onset of intense fear, which is associated with:

Rapid heart rate Sweating Trembling Choking sensation Shortness of breath
Chest pain Abdominal Pain Nausea Dizziness Numbness in hands
Chills Hot flashes Other:____________

These intensively fearful episodes last how long: Less than 10 minutes_____ More than 10 minutes______

How often are they occurring?________________________________ Last one happened?___________

Do you think about them happening in between episodes?	True	False
I have trouble controlling my worry about a lot of small things	True	False
I am anxious when around unfamiliar people/places	True	False
I have recurrent thoughts, which I unsuccessfully try to suppress	True	False
I have certain unique actions which I perform routinely	True	False
I routinely re-live a bad thing that happened to me	True	False
I have recurrent nightmares	True	False

Things that I avoid due to my fears are: ____

HABITS	Y/N	Age with first use	Date last used	Amount/day/week
Alcohol	____	______________	______________	______________
Cigarettes	____	______________	______________	______________
Smokeless tobacco	____	______________	______________	______________
Marijuana	____	______________	______________	______________
Prescription drugs (not prescribed to you)	____	______________	______________	______________
Illegal Street drugs	____	______________	______________	______________

CURRENT PSYCHIATRIC MEDICATIONS: (Including medications for nervousness or insomnia)

Name	Dosage	Duration of use	Is it beneficial?	Any side effects
__________________	________mg	_________________	__________________	______________
__________________	________mg	_________________	__________________	______________

CURRENT NON-PSYCHIATRIC MEDICATIONS:

Name	Dosage	Duration of use
______________________	__________mg	____________________________
______________________	__________mg	____________________________

MEDICATION ALLERGIES? Yes No **OTHER ALLERGIES** Yes No
If yes, list ____

INTAKE FORM

MENTAL HEALTH TREATMENT HISTORY: (if any) Individual, Couple's or Family Therapy
Dates________________________ Reason for therapy ____
Helpful Yes No explain ____

Hospitalizations (start with most recent)
Dates & Duration of stay____
Reason for hospitalization ____
____

PREVIOUS PSYCHIATRIC MEDICATIONS TRIED: (Be as complete as possible)

Name	Dosage	Duration of use	Helpful	List side effects
__________________	________mg	_________________	__________________	_______________

FAMILY PSYCHIATRIC HISTORY: (List all biological relatives who have been treated for, or have suffered from a psychiatric illness to include alcohol or drug addiction & suicide attempts).
Maternal: ____
Paternal: ____

PRESENT AND PAST MEDICAL PROBLEMS: ____
____

SURGERIES/HOSPITALIZATIONS: ____
____

SOCIAL HISTORY: Where were you born? _______________ Where did you grow up? ___________ # of brothers ______ Sisters _____ Happy Childhood? Yes No Did your parent's divorce? yes no What age, if yes Where did you grow up? ___________ Who raised you? Parents Foster care Grandparents Other: ______________________
Are your parents still living? Mother Yes No Father Yes No Who do you currently live with? ___________________
Have you been physically/sexually abused? (as a child or as an adult) Yes No Age____
Describe:____
____

EDUCATIONAL HISTORY:

School Grade Completed 1 2 3 4 5 6 7 8 9 10 11 12 Grades - Failed: _____ Skipped: ______ Held Back: _____
Current (if applicable)School _________________________ Counselor: _________________Class Type: Regular Gifted Special Ed.Academic Difficulties: Yes No Behavioral Problems: Yes No
College Level Completed: Associates Bachelors Masters Doctorate

Military: Yes No Branch___________ Dates___________ Rank_________

OCCUPATIONAL HISTORY:
Current Employer: ______________________ Job Title: _____________ How long? _____
Description of Duties: ____
Satisfying/Stressful Relationship with Boss: Yes No ____

INTAKE FORM

Prior Employer: ______________________________ Duration: _________________________

MARITAL HISTORY

Spouse Name	Years of marriage	# of children	If no longer married, state reason:
________________________	_________	_______	_____________________________
________________________	_________	_______	______________________________

Circle any marital issues you would like to address:
Infidelity communication trust parenting affection sex religion finance
Describe any marital issues for which you are seeking counseling:
____
____
____
____
____

Religious affiliation: (if any) ____

LEGAL ISSUES:
Incarcerations yes no Dates:_____________ Place: _________________ Reason:_____________
Current legal problems: Probation Custody battle Foreclosure Bankruptcy Others_________________
TRAUMATIC EVENTS: (Past and present, if any)
____

SEXUAL HISTORY:
Preference in sexual partner: (Circle any that apply) Opposite Sex Same Sex Both
If sexually active, at what age did you become sexually active? ___________
Please list any past or current sexual issues: ____
____
Have you had or do you now have any sexually transmitted diseases? Yes No
Explain: ____

ADDITIONAL INFORMATION: Please list any other information you think would be helpful for your therapist to know.
____
____
____
____
____
_____

Jmc/7.14/intake