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 Inc 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:
____

____

Please answer the following, taking into consideration patient's age/personality, based on the last 2 weeks:

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:____
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

MOOD SYMPTOMS (cont.)

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 cut/injured myself on purpose	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

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

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

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____

____

Present and past medical problems:____

____

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: ____

MARITAL HISTORY:

Spouse Name	Years of Marriage	#of children	If no longer married, state reason:
_________________________	_________	_______	_____________________________
_________________________	_________	_______	_____________________________

Long -term relationships	Years Together	#ofchildren	If no longer together, state reason:
_________________________	_________	_______	_____________________________

Circle any relationship issues you would like to address:

Infidelity communication trust parenting affection sex religion finance

Describe any relationship issues for which you are seeking counseling:

____

____

____

SOCIAL HISTORY: Where were you born? ________________ Where did you grow up? ______________

Who raised you? Parents Foster care Grandparents Other:_____________

# of brothers ______ Sisters _____ Happy Childhood? Yes No

Did your parent's divorce? Yes No What age, if yes?____________

Are your parents still living? Mother: Yes No Father: Yes No

Who do you currently live with? ________________________

RELIGIOUS AFFILIATION: (if any):____

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

OCCUPATIONAL HISTORY:
Military: Yes No Branch________________ Dates_________________ Rank______________________
Current Employer: ______________________ Job Title: _____________ How long? _____
Description of Duties: ____
Satisfying/Stressful Relationship with Boss: Yes No ____
Prior Employer: _______________________________ Duration: ________________________

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
Explain: ____

ADDITIONAL INFORMATION(strengths, physical activity, hobbies, etc):
Please list any other information you think would be helpful for your therapist to know ____________________________
____
____
____
____
____

JM Counseling
Helping on Your Journey