David L Johns LMHC
(407) 970-8814 solutionzone.org
465 SUMMERHAVEN DRIVE, SUITE A, DEBARY, FL 32713

CLIENT INTAKE

Please answer the following questions to the best of your ability. These questions are intended to help the therapist with the therapy process. All information is completely confidential.

Personal Information

Client Name:_____ Birth Date: ____/____/____
(Last) (First) (Middle Initial)

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

Number of Children: _____Ages:_____Stepchildren_____

Current Address:
_____
_____

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

Cell/other:_____ May we leave a message? □ Yes □ No

Email:_____ May we email you? □ Yes □ No

**NOTE: Emails are not considered confidential*

Parents living? ___ **Y** ___ **N Mother's age** ___ **Father's age** ___ **# Brothers** ___ **# of Sisters** ___
Where were you born? _____

Parents deceased? Mother – when? _____ **Cause** _____
Father – when? _____**Cause** _____

Referred by:_____

Are you here voluntarily (self referred) or at the suggestion or direction of another? Ex: attorney, judge, probation officer, parent, spouse, doctor,._____

*Have you had any counseling/therapy in the past? □ Yes □ No

Where: _____Name of providers:_____

When Approximate Dates: _____

_____

Medical Health, Substance Abuse, Mental Health Information

How is your physical health at the present time? _____

**Please list any persistent medical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, thyroid dysfunction, etc.):_____

_____

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Are you on any medication for **physical/medical issues**? □ Yes □ No
Specify:_____

Are you **currently** taking any ***psychiatric medications***? □ Yes □ No

What psych meds are you taking now? _____ Dosage: _____ Frequency: ___

_____Dosage: _____ Frequency: _____

_____ Dosage: _____ Frequency: _____

_____ Dosage: _____ Frequency: _____

Are you having any problems with your sleep habits? □ Yes □ No

If yes, check which applies: □ Sleep too much □ Sleep too little □ Poor quality □ Disturbing dreams

Are there any changes or difficulties with your eating habits? □ Yes □ No

If yes: □ Eating less □ Eating more □ Binging □ Restricting

Have you experienced a weight change in the last two months? □ Yes □ No

Do you consume alcohol regularly? □ Yes □ No

In one month, how many times do you have 4 or more drinks in a 24-hour period?_____

How often do you engage in recreational drug use?□ Daily □ Weekly □ Monthly □ Rarely □ Never

Have you felt depressed recently? □ Yes □ No If yes, for how long?_____

Have you had suicidal thoughts in your past? □ Yes □ No Suicidal attempts? □ Yes □ No

If yes, how long ago?_____ How often? □ Frequently □ Sometimes □ Rarely

Quick Check

Check the boxes of the symptoms you have recently been concerned about.

□ Extreme depressed mood □ Mood swings □ Rapid speech

□ Anxiety □ Panic attack □ Phobia □ Disturbed sleep □ Hallucinations

□ Memory lapse □ Alcohol/drugs □ Body complaints □ Eating disorder

□ Repetitive thoughts □ Grief/Loss □ Repetitive behaviors □ Headaches

□ Domestic Abuse □ Physical health □ Traumatic Experience □ Relationship

Additional Comment about what you checked off above:

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Relationship / Marriage

Are you currently in a romantic, marital, or otherwise committed relationship? □ Yes □ No If yes, how long have you been in this relationship?_____ Partner/Fiance/Spouse's First name_____

On a scale from 1-10, how would you rate the quality of your relationship (10 being great 1 opposite)? _____

In the last year, have you had any major life changes (e.g. new job, new home, illness, relationship change, etc.)? _____

_____

Have you experienced a trauma at any time in your life that you feel you haven't Fully recovered from? _____

_____

Occupational & Educational Information

Are you currently employed? □ Yes □ No If yes, who is your employer?_____ What is your position?_____
Are you happy in your current position? □ Yes □ No Does your work make you stressed? □ Yes □ No What is stressful about it? _____

_____

Educational achievements:

□ High School/GED □ Some college □ Bachelors □ Masters □ Doctorate

□ Trade school/certification □ Other: _____

Area of Concentration: _____

Have you been arrested and/or convicted of any crime?_____

When_____ **Offense**:_____

Current Legal Status: (probation/parole, etc) _____

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Billing Information:

If you have provided counselor with this info already, disregard

Insurance Company _____
Who is subscriber? _____
Date of Birth of Subscriber_____
Member ID: _____
Is insurance still active? _____
Is preauthorization needed for outpatient psychotherapy? _____ (Usually "no")
Do you know what your co-payment or co-insurance is? $_____ copay
_____% coinsurance

HAVE YOU MET YOUR DEDUCTIBLE? _____

If using your **Employee Assistance Benefits**, what is the name of your EAP? _____
What is the authorization number? _____ Number of visits authorized___

I understand that the information I provided in this document is confidential and protected health information guaranteed by HIPAA Federal Privacy Law. A copy of this Privacy statement is on solutionzone.org

X **X**

_____

Client Signature **Date**