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 to begin 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: _____Their ages:_____Stepchildren_____Their ages:_____

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: Mother's age _____ Father's age _____ # Brothers ____ # of Sisters _____
(Indicate if deceased with letter "D") Where are you in the birth order? _____
Where were you born? _____How long have you lived in Florida? _____

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:_____ Helpful?:_____

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 ***medications for mood improvement or anxiety/stress***?

□ Yes □ No

What psych meds are you taking now?

_____ Dosage: _____ Frequency: _____ Start date: _____
_____ Dosage: _____ Frequency: _____ Start date: _____
_____ Dosage: _____ Frequency: _____ Start date: _____

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
□ Addiction or Addiction Recovery

What I am most intending to resolve in therapy is:

_____

_____

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Are you aware of any previous or early childhood traumatic experiences that might have contributed to your current concerns? ___ Y ___ N ___ ?

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/Fiancé/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.)?

_____

_____

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:

Please attach a copy of your Insurance Card and Driver License to this page. If you unable to make copies, your provider will make a copy of it and return it to you.

Insurance Company _____Who is subscriber? _____

Date of Birth of Subscriber_____Member ID:_____

Do you know what your co-payment or co-insurance is? $_____copay
____% coinsurance

Is YOUR DEDUCTIBLE needing to be met before benefits are activated? _____
If uncertain please call Member/Customer Service prior to first visit.

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. I have been given a copy of this Privacy statement

Initial here: X _____

I understand that cell phones are to be turned OFF and recording devices are not permitted during sessions.

X **X**

_____

Client Signature **Date**