Awakening Connections Therapy LLC **Client Name: _____**

I N T A K E F O R M

Please provide the following information and answer the questions below. Please note:
Information you provide here is protected as confidential information.

Please fill out this form and bring it to your first session.

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

Name of parent/guardian (if under 18 years): _____
(Last) (First) (Middle Initial)

Birth Date: _____ /_____ /_____ Age: _____ Gender: _____

Marital Status:
□ Never Married □ Domestic Partnership □ Married □ Separated □ Divorced □ Widowed

Please list any children/age: _____

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 note: Email correspondence is not considered to be a confidential medium of communication.

Referred by (if any): _____
May I thank them? □ Yes □ No

Emergency Contact (Name / Relationship / Phone #'s): _____

_____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?
□ No □ Yes, previous therapist/practitioner: _____

Are you currently taking any prescription medication?
□ Yes, please list below □ No

_____

_____

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updated 2/2016

Have you ever been prescribed psychiatric medication? □ Yes □ No
Please list each, and provide dates prescribed: _____

_____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:

_____

2. How would you rate your current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:

_____

3. How many times per week do you generally exercise? _____

What type(s) of exercise do you participate in? _____

4. Please list any difficulties you experience with your appetite or eating patterns _____

_____

5. Are you currently experiencing overwhelming sadness, grief or depression? □ No □ Yes
If yes, for approximately how long? _____

6. Are you currently experiencing anxiety, panic attacks or have any phobias? □ No □ Yes
If yes, when did you begin experiencing this? _____

7. Are you currently experiencing any chronic pain? □ No □ Yes
If yes, please describe _____

8. Do you drink alcohol more than once a week? □ No □ Yes (amount / type): _____

9. Do you engage in recreational drug use? Substance(s): _____

□ Daily □ Weekly □ Monthly □ Infrequently □ Never

10. Are you currently in a romantic relationship? □ No □ Yes
If yes, for how long? _____

On a scale of 1-10 (with 10 being INCREDIBLE), how would you rate your relationship? _____

11. What significant life changes or stressful events have you experienced recently: _____

_____

_____

FAMILY MENTAL HEALTH HISTORY:

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

	Please Circle	List Family Member
Alcohol/Substance Abuse	yes/no	
Anxiety	yes/no	
Depression	yes/no	
Domestic Violence	yes/no	
Eating Disorders	yes/no	
Obesity	yes/no	
Obsessive Compulsive Behavior	yes/no	
Schizophrenia	yes/no	
Suicide Attempts	yes/no	

ADDITIONAL INFORMATION:

1. Are you currently employed? □ No □ Yes
If yes, what is your current employment situation? _____

_____

What do you enjoy about your work? What is stressful about your current work? _____

_____

_____

2. Do you consider yourself to be spiritual or religious? □ No □ Yes
What is important for me to know or understand about this part of your life? _____

_____

_____

3. What do you consider to be some of your strengths?

_____

_____

_____

_____

4. What do you consider to be some of your weaknesses?

_____

_____

_____

_____

5. What would you like to accomplish with your time in therapy?

_____

_____

_____

_____

6. Is there anything more you would like me to know?

_____

_____

_____

_____

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