

Connect Therapies Intake

Client's Name _____ **Date of Birth** _____
Social Security # _____ **Gender** _____ **Marital Status** _____

Client's Address: Street/ Apt: _____
City, State Zio _____

O.K. to mail to this address? ___

Home Phone: _____ **Cell Phone:** _____

O.K. to contact and leave a message at these numbers? Home _____ Cell _____

email address _____ How do you prefer that I contact you? _____

Emergency Contact Information:

Name _____ Relationship _____

Phone _____ O.K. to leave a message at this number? _____

Ethnicity: ___ Native American ___ Asian American ___ Black/African American ___ Latino ___
Multiracial ___ Pacific Islander ___ White ___ Other ___ Unknown

Religious/ Spiritual History:

Your religion or spiritual practice: _____

Has there been a recent change in your religious/ spiritual beliefs? _____

(If yes, please explain _____)

How important is religion to you? _____

How important is it to your family? _____)

Level of Education:

___ None ___ Elementary School ___ Middle School ___ High School ___ GED
___ Vocational Training ___ Some College ___ College Degree ___ Graduate / Professional
School Are you currently enrolled as a student? _____

Sexual Orientation: ___ Heterosexual ___ Gay ___ Lesbian ___ Bisexual ___ Transgendered

If client is a minor:

Is the child living with:

___ both biological parents ___ single biological parent ___ divorced or remarried parent

___ legal guardian (explain relationship to child) ___ other (explain relationship to child)

Employment Information:

Name of Employer: _____ Employee Address: _____

Work Phone: _____

Insurance Information: (If using insurance, Medicaid, Medicare)

Name of Insurance Company: _____

Phone Number: _____

Insured's Name: _____ Group/ID Number: _____

Medicaid Number _____ Medicare Number: _____

Developmental / Childhood History:

Please give a brief description of your childhood: _____

Any neonatal irregularities, birth trauma, postpartum depression, health trauma?

Are you adopted? ____ If so, at what age? ____

Please describe your temperament...

As a child: _____

As an adult: _____

Of your mother: _____

Of your father: _____

As a child did you have trouble relating with:

____ Other children ____ Teachers ____ Brothers/ Sisters ____ Parents ____ Other Adults

Please explain: _____

Describe your current emotional state. _____

Goals of Counseling:

Please tell me what you want to change. _____

How long has this been a problem? _____

When did this problem first appear? _____

What changes have you noticed recently? _____

Have you tried to solve this problem? _____

Why are you seeking help at this time? _____

How will you know when the problem is solved? _____

Change is usually difficult. In the past, what strengths and skill have you used to assist you in making changes? They will be helpful in solving this problem. _____

Have you experienced any of the following events recently?

____ Deaths

____ Violence in Family

____ Moves

____ Abuse in Family

____ Medical Problems

____ Legal Problems

____ Financial Stressors

____ Addiction in Family

Are you currently having suicidal thoughts or ideations? ____ If so do you have a plan to carry them out? _____

Are you currently having homicidal thoughts or ideations? ____ If so do you have a plan to carry them out? _____

Family Composition:

Please list family and/ or significant others living in your household.

Member Relationship Age Occupation & level of Education _____

Family History:

Have you or any other family members received psychiatric or mental health treatment? ____
 When? _____

Therapist's Name _____ Phone Number _____

O.K. to contact? ____

If yes, please indicate who and briefly explain the circumstances _____

Have any of your biological (blood) relatives, e.g. brothers, sisters, mother, father, aunts, uncles, and grandparents experienced any of the following conditions?

(Please indicate which relative and whether they are on your mother's (M) or father's (F) side of the family.) Ex. Grandmother M F)

Condition	Family Member(s)	Mothers or Fathers side
Depression	_____	____M ____F
Panic Attack	_____	____M ____F
Anxiety	_____	____M ____F
Hyperactivity (A.D.D. or A.D.H.D.)	_____	____M ____F
Autism Spectrum Disorder / Aspergers	_____	____M ____F
Learning Disability	_____	____M ____F
Oppositional Defiant Behavior	_____	____M ____F
Tic Disorder	_____	____M ____F
Hypo or Hyper Thyroid	_____	____M ____F
Diabetes	_____	____M ____F
Heart Disease	_____	____M ____F
Attempted Suicide	_____	____M ____F
Completed Suicide	_____	____M ____F
Physical Abuse	_____	____M ____F
Sexual Abuse	_____	____M ____F
Alcohol Problems	_____	____M ____F
Drug Problems	_____	____M ____F
Problems with the Law	_____	____M ____F
Schizophrenia	_____	____M ____F

Huntington's Chorea	_____	_____ M _____ F
Parkinson's Disease	_____	_____ M _____ F
Multiple Sclerosis	_____	_____ M _____ F
Early Onset Dementia	_____	_____ M _____ F
Manic- Depressive (Bipolar)	_____	_____ M _____ F
Obsessive Compulsive Behavior	_____	_____ M _____ F

Previous Testing or Therapy:

Have you had previous psychological testing? _____
 If yes, Where? _____ When? _____
 What were the results? _____
 Previous Therapy? _____
 If yes, who was your therapist? _____
 Approximately when and for how long did you attend therapy? _____
 Did treatment include medication? _____ If yes, what medications did you take and for how long?
 Effectiveness of therapy treatment: _____ Positive _____ Negative _____ No Change
 Reason you discontinued therapy _____
 Previous mental health inpatient or day treatment?
 If yes, Treatment Facility _____
 Have you ever worked with a Coach? _____ If yes, who? _____
 Last seen _____

Substance Use:

_____ Alcohol
 _____ Tobacco
 _____ Cannabis
 _____ Amphetamines _____ Hallucinogens _____ Inhalants
 _____ Cocaine/ Crack _____ Ecstasy (MDMA)
 _____ Over the Counter
 _____ Prescription Meds
 Other _____
 Previous substance abuse residential or day treatment?
 If yes, Treatment Facility _____
 Has anyone in your family been hospitalized for alcohol or drug dependence?
 _____ Parents _____ Step-parents _____ Other adults in household _____ Other Significant Adult

Are you currently on probation or parole? _____

Officer Name _____ Officer Contact Information _____
 Charged with _____ Pending court case? _____

History of Abuse:

_____ Physical abuse Client was _____ Victim _____ Perpetrator _____ Sexual abuse Client was _____ Victim _____ Perpetrator _____ Emotional abuse Client was _____ Victim _____ Perpetrator
 _____ Neglect Client was _____ Victim _____ Perpetrator
 _____ Abandonment Client was _____ Victim _____ Perpetrator
 Describe any abuse listed above _____

Family History of Abuse:

- ___ Client's parents were/ are abusive to each other
- ___ Client's parents were/ are abusive to their children
- ___ Client's siblings were/ are abusive to each other

Describe any abuse listed above _____

Current Abuse: Most Recent Incident: _____ First Incident: _____

Safety Plan Created? _____

If yes, date of safety plan _____

Other information _____

Social Services Involved? _____

Disposition of Investigation? _____

How did you learn about my Practice? _____

May I send a thank you note for you referral? _____

I attest that the above information is true to the best of my ability.

Client's Signature _____ **Date** _____

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