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: ___NativeAmerican ___AsianAmerican___Black/AfricanAmerican ___ 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: _____

Presenting Issue: (What is the reason for seeking help?) _____
_____
_____
Did anything happen at the same time that this issue began that may have caused the problem?
_____
If so, when and what was happening at that time?
_____
_____
How long have you had these problems? _____

Medical and Developmental History:
Are you currently under Medical Treatment? ____
Name of Primary Care Physician _____ Date last seen: _____
Dr. Address _____Phone Number _____
May I contact your physician? ____ If yes, you will be required to sign a release of information.

Are you currently or have you recently experienced the following?
___ Headaches
___ Meningitis or Encephalitis
___ Head Injury
___ Frequent Ear Infections ___ Vision Problems
___ Dizziness
___ Hearing Difficulties ___ Allergies/ Asthma
___ Seizures
___ Memory Issues
___ High Blood Pressure ____ Low Blood Pressure
___ Nausea
___ Several High Fevers
___ Weakness
___ Hospitalizations _____
___ Head Injuries _____
___ Broken Bones
___ Surgeries _____
___ MedicationAllergies
___ Last Menstrual Period _____
___ Pregnant
___ StomachAches
___ Diabetes ___ Pre-diabetic ____ Hypoglycemic
___ Cancer _____

Current Medication (Names and Dosages) ex. Xanax 20 mg. 2x/ day
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

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 _x_ 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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