Connect Therapies Intake

Client's Name_____ **Date of Birth**_____

Social Security #_____ Marital Status _____

Client's Address:

Street/ Apt: _____

City, State Zip _____

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? ___ text __ email __ phone

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:

___ Bisexual
___ Gay
___ Heterosexual
___ Lesbian
___ Non-binary
___ Pan sexual
___ Questioning
___ Queer
___ Transgendered

Employment Information:

Name of Employer: _____

Employee Address: _____
_____

Work Phone: _____

Insurance Information: (If not self pay or private pay)

Name of Insurance Company: _____

Phone Number: _____

Insured's Name:_____ Group/ID 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 (ROI).

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?
These strengths 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 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 treatmen**t?
If yes, Treatment Facility_____
Have you ever worked with a Coach? ___ If yes, who? _____
Last seen _____

Have any **family members** received **psychiatric or mental health treatment**? ____
When? _____
Therapist's Name _____ Phone Number_____
If yes, please indicate briefly explain the circumstances
_____

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 /date: _____
First Incident/date:_____
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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