Client Intake Form

Date of first appointment:

Thank you for taking the time to complete this intake form. This form includes questions that are designed to give me an understanding of you or your child's needs and how we can get you started on the right track. Your information is confidential and will not be shared without your consent. Let's get started.

Referred by:

____ Medical Provider: _____

____ HTBH website:

____ Friend/family: _____

____ Other: _____

Have you previously received any types of mental health services?

____ Yes

____ No

If yes, which of the following:

____ Psychotherapy

____ Medication

____ Outpatient Hospitalizations

____ Inpatient Hospitalizations

If yes, please provide:

Name of facility: _____

Location: _____

Dates of treatment: _____

Reason for treatment: _____

Briefly explain why you are seeking help today

When did your problem first start?

_____ Last week

_____ Two weeks ago

_____ 30 days ago

_____ During adolescence

_____ During childhood

What areas of your or your child's life have been affected because of this problem?

What areas of your or your child's life have been affected because of this problem?

Are you or your child currently experiencing overwhelming sadness, grief or depression?

_____ Yes

_____ No

If yes, how long have you or your child been experiencing this?

Are you or your child currently experiencing anxiety, panic, or have any phobias?

_____ Yes

_____ No

If yes, when did you or your child begin experiencing this? _____

Please describe any major losses or traumas you or your child have experienced:

What significant life changes or stressful events have you or your child experienced recently?

What would you or your child like to accomplish during the time with HTBH?

FAMILY HISTORY

Where were you or your child born? _____

Where did you or your child grow up? _____

_____ City

_____ Suburbs

_____ Country

List any parents and siblings if applicable. You can use additional space on the back of the page if needed.

Name	**Age**	**Relationship**	**They're location**	**If decease, age and cause of death**

Who raised you as a child? _____

Or who raised your child? _____

Mother's Occupation: _____

Father's Occupation: _____

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

Condition	**Please circle**	**Relationship to family member**
Alcohol/Substance Abuse	yes/no	
Anxiety	yes/no	
Depression	yes/no	
Domestic Violence	yes/no	
Sexual Abuse	yes/no	
Eating Disorders	yes/no	
Obesity	yes/no	
Obsessive Compulsive Disorder	yes/no	
Schizophrenia	yes/no	
Suicide Attempts	yes/no	
Other diagnosed mental health condition	yes/no If yes, what type?	

Marital Status

____ Single, never married

____ Married

____ Separated

____ Divorced

____ Widowed

____ Involved in a relationship

If married, how long have you been married?

On a scale from 1-10, 1 being extremely dissatisfied and 10 being extremely satisfied, how would you rate your marriage relationship if applicable _____.

Please list any children that you have whether biological, adopted, foster child. Include their names, and ages:

Name	**Age**	**Relationship**	**They're location**	**If decease, age and cause of death**

PHYSICAL HEALTH

Please list any medications, herbs, or supplements. Be sure to include the condition, as some medications are prescribed for off-label use. Continue on the back if needed, or provide a separate list. If you have a complicated medical profile, please supply supporting documentation to be able to facilitate a comprehensive understanding of your health.

Medications/ Supplements	**Dosage**	**Condition**	**Start/End Date**

Prescribing provider and contact information:

Name: _____

Specialty: _____

Facility: _____

Phone, email, or Fax:

_____

How would you rate your or your child's current physical health?

_____ Poor

_____ Unsatisfactory

_____ Satisfactory

_____ Good

_____ Very Good

Please list any specific health problems you or your child are currently experiencing:

How would you rate your or your child's current sleeping habits?

_____Poor

_____Unsatisfactory

_____ Satisfactory

Good

Very Good

If you are having problems, in which phase of sleep are you or your child experiencing issues?

_____ Falling asleep

_____ Staying asleep

_____ Awakening early

_____ Sleep apnea

Please list any other specific sleep problems you or your child is currently experiencing:

How many times per week do you or your child generally exercise? _____ What types of exercise do you participate in:

Are you or your child currently experiencing any chronic pain?

_____ No

_____ Yes

If yes, please describe:

Please describe current use of alcohol, cigarettes, and/or recreational drugs:

Please describe previous use of alcohol, cigarettes, and/or recreational drugs:

ADDITIONAL INFORMATION

What do you enjoy about your work (full-time homemaker included)? If retired, what did you enjoy about your work? If applicable

What activities does your child enjoy doing? If applicable

What do you find particularly stressful about your current or previous work?

What do you enjoy doing in your free time? What do you do to relax?

Do you consider yourself to be spiritual or religious? If yes, please describe your faith or belief:

What do you consider to be some of your or your child’s weaknesses?

What do you consider to be some of your or your child's strengths?