

DC VA Counseling Psychotherapy, LLC

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CLIENT INTAKE FORM

Please provide the following information for my records.

Leave blank any question you would rather not answer or does not apply to you.
Information you provide here is held to the same standards of confidentiality as our therapy.

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

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

Birth Date: ____ / ____ / ____ **Age:** ____

Gender: Male Female Other

Address:

(Street and Number)

(City) (State) (Zip)

Home Phone: () - **Cell/Work Phone** () -

Email: _____ May I email you? Yes No

I give permission to be called/text at: HOME: Yes__ No__ CELL/WORK: Yes__ No__

Please Initial _____

Emergency Contact: _____ **Emergency Contact Phone:** _____

Marital Status:

Never Married Partnered Married Separated Divorced Widowed

Number of Children: _____ **Ages:** _____

How did you hear about us? (Referred by/Found us on:

Current reason for seeking therapy:

HEALTH AND SOCIAL INFORMATION

1. How is your physical health at present? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

2a. Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.)

2b. What medications are you currently taking? Please list them here.

3. Are you having any problems with your sleep habits? No Yes

If yes, check where applicable:

Sleeping too little Sleeping too much Poor quality sleep
Disturbing dreams Other _____

4. How many times per week do you exercise? _____

5. Are you having any difficulty with appetite or eating habits? No Yes

If yes, check where applicable:

Starving myself Eating less Eating more Binging Vomiting

Have you experienced significant weight change in the last 6 months?

No Yes

6. How often do you regularly use alcohol? Never Rarely Daily

In a typical week, how often do you have 4 or more drinks in 24-hours? _____

7. How often do you engage in recreational drug use?

Daily Weekly Monthly Rarely Never

8. Have you had suicidal thoughts recently or in the past? When? _____

Frequently Sometimes Rarely Never

9. Are you currently in a romantic relationship? No Yes

If yes, how long have you been in this relationship? _____

On a scale of 1-10, how would you rate the quality of your current relationship? _____

Do you feel safe the relationship is affecting other aspects of your life? Yes No

10. In the last year, have you experienced any significant life changes or stressors?

Have you ever experienced or are you currently experiencing (mark with an “X”:

- | | |
|--|----------------------------|
| Unfulfilled relationships | Depressed mood |
| Mood Swings | Irritability |
| Rapid Speech | Anxiety/Anxious Thought |
| Panic | Phobias |
| Anger/Rage | Sleep Disturbances |
| Hallucinations | Unexplained losses of time |
| Unexplained memory lapses | Alcohol/Substance Abuse |
| Frequent body complaints | Eating disorder |
| Body image problems | Impulsive behavior |
| Loss of concentration | Uncontrolled grief |
| Homicidal Thoughts | Suicide Attempt |
| Self-Injury/Cutting | Abuse |
| Significant Traumatic Experience | |
| Repetitive thoughts (e.g., Obsessions) | |
| Repetitive behaviors (e.g., Frequent Checking, Hand-Washing) | |

Are you currently receiving or have you in the past received psychiatric services, professional counseling or psychotherapy elsewhere? Yes No
If yes, please list helping professional, time, and reasons:

Are you currently taking prescribed psychiatric medication (antidepressants or others)?
Yes No If yes, please list:

If no, have you been previously prescribed psychiatric medication? Please list:
Have you ever been hospitalized? Yes No If yes, when and for what?

OCCUPATIONAL INFORMATION

Are you currently employed? Yes No

If yes, are you happy at your current position? _____

On a scale of 1-10, how satisfied are you in your current position? _____

Please list any work-related stressors, if any _____

RELIGIOUS/SPIRITUAL INFORMATION

Do you consider yourself to be religious? No Yes

If yes, what is your faith? _____

If no, do you consider yourself to be spiritual? No Yes

On a scale of 1-10, how spiritual do you consider yourself? _____

SEXUAL HEALTH HISTORY

Are any of your current concerns related to your sexuality? Yes No

If yes, what are your concerns? _____

FAMILY MENTAL HEALTH HISTORY

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (circle any that apply and list family member, e.g., Sibling, Parent, Uncle, etc.):

Difficulty			Family Member
Depression	yes	no	
Bipolar Disorder	yes	no	
Anxiety Disorders	yes	no	
Panic Attacks	yes	no	
Schizophrenia	yes	no	
Substance Abuse	yes	no	
Eating Disorders	yes	no	
Learning Disabilities	yes	no	
Trauma History	yes	no	
Suicide Attempts	yes	no	If yes, how many _____.

OTHER INFORMATION (Write in the back)

What do you consider to be your strengths and weaknesses?

What do you like most and least about yourself?

Do you have anybody you would say is a source of support for you?

Have you thought of your goals for therapy? If so please list them. If not, it is ok.