# 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.