Yvonne Clayton, MA, LMHC

CLIENT INTAKE

Please provide the following information by filling out this form and bringing it to your first session.

Please note: Information you provide here is protected as confidential information.

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

Birth Date: ______ /______ /______ Age: ________ Gender: □ Male □ Female

Address:____
(Street and Number)

____
(City) (State) (Zip)

Home Phone:__________________________ May I leave a message? □ Yes □ No

Cell/Other Phone:________________________ May I leave a message? □ Yes □ No

E-mail: _______________________________________May I email you? □ Yes □ No

*Please note: Email correspondence is not considered to be a confidential medium of communication.

Referred by:____

Areas of concern or problems that bring you to therapy_________________________________

____

____

GOALS you would like to address in therapy:

1. (primary goal)____

2.____

3.____

Client ____________________

How will you know when you reached your goals?___________________________________

____

What have you done in the past that you found helpful?_______________________________

____

RELATIONSHIPS:

Your Relationship Status:

□ Never Married □ Domestic Partnership □ Married □ Separated □ Divorced

□ Widowed / How Many years?________________________________

On a scale of 1-10, how would you rate your relationship (10 high) ______________________

If you have children, list gender & ages, and/or others present in your household:

____

____

Other relationship concerns:

____

____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. Rate your current physical health? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

List any specific health problems you are currently experiencing:

____

2. Are you currently experiencing any chronic pain? □ No □ Yes If yes, please describe:

____

3. How many times per week do you generally exercise? __________

Client ____________________

What types of exercise do you participate in ____

4. Are you currently experiencing any of the following symptoms? (please circle):

Anxiety	Depression	Memory Difficulties
Panic	Loss of Interest	Anger
Loss of Appetite	Agitation	Helplessness
Dizziness	Too little sleep	Procrastination
Compulsions	Too much sleep	Confusion
Social Withdrawal	Hearing Voices	Easily Tearful
Obsessiveness	Loneliness	Visual Hallucinations
Sadness	Lack of Concentration	Thoughts that scare you
Grief	Difficulty initiation activity	Fatigue
Fear	Weight Gain	Excessive happiness
Nightmares	Weight Loss	Increased Disorganization
Impulsiveness	Outbursts	

Rate (circle) your mood on a 0/10 scale: LOW < 1 2 3 4 5 6 7 8 9 10 >HIGH

5. Have you ever had a head injury or concussion? ____Yes ____No

If yes, when and how did this concussion or head injury occur?__________________________

____

6. Have you previously received any type of mental health services (psychotherapy, couples counseling, psychiatric services, etc.)? ____Yes ____No

If yes, name of previous therapist/practitioner an dates:___________________________________

____

Previous psychiatric hospitalizations? ____

Client _____________________

Are you currently being prescribed medication for mental health? ____Yes ____No

If yes, please list medication(s):____

____

In the past, were you prescribed medication for mental health? ____Yes ____No

If yes, please list medication(s) and provide dates:_______________________________________

____

Have you in the past (or currently) used alternative medications, supplements, or mental health treatments? _____Yes _____No If yes, please list and provide dates (circle those that you found most helpful):____

____

7. Do you drink alcohol? ____Yes ____No If yes, please list amount and how often (within a week)____

8. Do you use recreational drugs? ____Yes ____No If yes, how often? □ Daily □ Weekly □ Monthly What types?______________________________________

____

9. Have you had any inpatient or outpatient treatment for alcohol or drug use? ____Yes ____No

If yes, please explain:____

FAMILY MENTAL HEALTH HISTORY:

In the section below, identify if there is a family history of any of the following: If yes, please indicate the family member's relationship to you in the space provided (father, mother, aunt, etc.).

	Please Circle	List Family Member(s)
Alcohol/Substance Abuse	yes / no	__________________________
Anxiety	yes / no	__________________________
Depression	yes / no	__________________________
Domestic Violence	yes / no	__________________________

Client ______________________

Obsessive Compulsive Disorder	yes / no	________________________
Other ________________________	yes / no	________________________
Other________________________	yes / no	________________________
Suicide Attempts	yes / no	________________________

ADDITIONAL INFORMATION:

10. Are you currently employed? □ Yes □ No If yes, what is your current employment situation?____

____

Do you enjoy your work? Is there particular stress or problems in your current employment?

____

11. Favorite interests, activities or experiences? ______________________________________

____

12. What ethnicity(s) does client and client's family identify with?_________________________

Are there any concerns or difficulties that client is experiencing related to ethnicity or culture?____

____

13. Do you consider yourself to be spiritual or religious? □ Yes □ No If yes, please describe your spirituality, faith or belief (if you would like):_______________________________

____

14. What do you consider your greatest strengths?______________________________________

____

____

Client _____________________

I understand that completion of the above is for informational purposes and does not constitute a contract for services as further therapy concerns are generally addressed during the first appointment. I agree to pay for sessions at the time of the appointment. If insurance is being utilized, I agree that it is my responsibility to understand my coverage, co-pays and deductibles, if any.

____

Name (Printed) Signature Date

____

Name (Printed) Signature Date

Client ______________________