COMPREHENSIVE CONFIDENTIAL INTAKE

HOLISTIC PSYCHOTHERAPY, TRAUMA-INFORMED COACHING & SPIRITUAL DIRECTION

IF THERE IS INSUFFICIENT SPACE, PLEASE FEEL FREE TO USE THE BACK SIDE OF THE FORM OR ADD MORE PAGES AS NEEDED.

Name:____ Date: ____________________

Address:____ Birthdate: __________________

City/State/Zip:_______________________________________ Home Phone: _______________

Email: ____ Work Phone: _______________

How were you referred to me: ________________________ Cell Phone: ________________

Profession: ____

Sexual Orientation: ☐ Heterosexual ☐ Homosexual/Lesbian ☐ Pan/Bisexual ☐ Other: ______________

Gender Identity: ☐ Male (Cis) ☐ Female (Cis) ☐ Transgender ☐ Transsexual ☐ Pangender/Androg

☐ Intersex ☐ NonBinary ☐ Gender Queer ☐ Gender Questioning ☐ Other: ____________________

☐ Single ☐ Divorced ☐ Widowed ☐ Married/Partnered ☐ Boyfriend/Girlfriend ☐ Other: _________

Name of spouse, partner, boyfriend/girlfriend ____

Do you live together? Y / N If yes, how long? ____

Who (else) do you live with? ____

Please list the names of your parents (include stepparents), siblings, and yourself in order of age. _____________

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If you have children please list their name, age and gender along with any other information about them you think it might be helpful for me to know (e.g. living arrangements, disabilities, etc)

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____

What are your main reasons for coming to counseling/coaching? _____________________________________

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CLIENT NAME: ____________________

Condition Checklist: Physical issues can directly impact psychological functioning and vice versa. Please check the conditions that apply to you now or in the past and add your comments below.

Musculo-Skeletal
- ❑ Headaches
- ❑ Muscle tension
- ❑ Joint stiffness/swelling/pain
- ❑ Spasms/cramps
- ❑ Broken/fractured bones
- ❑ Strains/sprains
- ❑ Back/hip pain
- ❑ Shoulder/neck pain
- ❑ Arm/hand pain
- ❑ Leg/foot pain
- ❑ Chest/ribs/abdominal pain
- ❑ Jaw pain/TMJ
- ❑ Tendonitis / Bursitis
- ❑ Arthritis
- ❑ Osteoporosis
- ❑ Scoliosis
- ❑ Bone/joint disease
- ❑ Other____________________

Skin
- ❑ Rashes
- ❑ Allergies
- ❑ Eczema
- ❑ Athlete's foot
- ❑ Acne
- ❑ Other____________________

Sexual
- ❑ Gender dysphoria
- ❑ Erectile dysfunction
- ❑ Premature ejaculation
- ❑ Painful intercourse
- ❑ Sexual aversion/lack of desire
- ❑ Other _____________________

Reproductive System
- ❑ Pregnancy
  - □ Current □ Previous
- ❑ Abortion
- ❑ PMS/PMDD
- ❑ Menopause
- ❑ Endometriosis/Fibroids
- ❑ Other____________________

Digestive/Urinary
- ❑ Indigestion
- ❑ Constipation - Chronic
- ❑ Intestinal gas/bloating
- ❑ Diarrhea - Chronic
- ❑ Diverticulitis or Colitis
- ❑ Irritable bowel syndrome
- ❑ Crohn's disease
- ❑ Interstitial cystitis
- ❑ Other: __________________

Circulatory and Respiratory
- ❑ Shortness of breath
- ❑ Fainting
- ❑ Cold feet or hands
- ❑ Cold sweats
- ❑ Swollen ankles
- ❑ Varicose veins / Blood clots
- ❑ Stroke
- ❑ Heart condition
- ❑ Allergies
- ❑ Sinus problems
- ❑ Asthma
- ❑ Low or High blood pressure
- ❑ Lymphedema
- ❑ Other____________________

Nervous System
- ❑ Numbness/tingling
- ❑ Fatigue
- ❑ Chronic pain
- ❑ Sleep disorders
- ❑ Ulcers
- ❑ Paralysis
- ❑ Herpes/shingles
- ❑ Cerebral palsy
- ❑ Epilepsy
- ❑ Chronic fatigue syndrome
- ❑ Multiple sclerosis
- ❑ Muscular dystrophy
- ❑ Parkinson's disease
- ❑ Spinal cord injury
- ❑ Other____________________

Other
- ❑ Surgeries
- ❑ Fibromyalgia
- ❑ Diabetes Type I
- ❑ Diabetes Type II
- ❑ Multiple Sclerosis
- ❑ Pernicious Anemia
- ❑ Sickle Cell Anemia
- ❑ Cancer
- ❑ Hypothyroid
- ❑ Hyperthyroid
- ❑ HIV/AIDS/Infectious Condition
- ❑ Visually impaired
- ❑ Hearing impaired
- ❑ Other ____________________

Comments for any check boxes on previous page:____

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____

Please describe any self-care practices (include exercise): ________________________________

____

____

How would you describe your racial/ethnic/cultural background? ____________________

____

How would you define your faith system/religion and what spiritual practices do you engage in? ____________________

____

____

How would you describe your relationship with your body? ____________________

____

How do you express your sexuality/get your sexual needs met? ____________________

____

On average, how many hours per night do you sleep? ____________________

How would you describe your eating habits? ____________________

Sugar Intake: ____________ Processed Food? ____________ Caffeine: ____________

Medications:

Current non-prescription medications, supplements & vitamins ____________________

____

____

Current prescription medications (include doses)____________________

____

Previous/Discontinued prescription medications (include doses)____________________

____

Other Medical:

Current Physicians	Type of Care
	Primary Health Care Provider

When was the last time you had a full physical evaluation? ____________________

Did you have a blood panel done at that time? ☐ Yes ☐ No

If so, what were the results? ____________________

Is your medical plan a PPO ☐ Yes ☐ No ☐ I don't know ☐ I don't have medical insurance

Please note that I am not on any insurance panels. If you are seeing me for psychotherapy and have a PPO, you might receive reimbursement for my services. I am happy to provide you with a receipt with appropriate insurance codes so that you may attempt to get reimbursement from your insurance company. I do not bill insurance companies directly nor do I have any interaction with them.

Other medical history that hasn't been noted: ____________________

____

____

Symptom Checklist: Please check any of the following symptoms that apply to you:

	Now	During Past Year		Now	During Past Year
Feel sad			Explosive Temper		
Loss of interest			Mood swings		
Feel hopeless			Feel on edge		
Nothing is fun			Worry too much		
Loss of appetite			Impatient		
Weight loss			Panicky		
Weight gain			Dry mouth		
No energy			Bowel problems		
Cry easily			Hyperventilation		
Can't concentrate			Faintness/dizziness		
Forgetfulness			Pounding heart		
Can't fall asleep			Perseverating thoughts		
Sleep too much			Trembling		
Guilt feelings			Sweating		
Restlessness			Chocking sensations		
Irritable mood			Nausea		
Think of suicide			Chest pain		
No desire to live			Undifferentiated fear		
Waking up early			Anxiety or fear of:		
Feel worse in the AM			Crowds		
No need for sleep			Busses		
Talking too much			Stores		
Racing thoughts			Heights		
Buying sprees			Talking in public		
Reckless driving			Going crazy		
Sexually overactive			Dying		
Uncontrollable urges			Other		

Say more about anything you've checked: ____________________

____

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Chemical Dependency / Abuse History

1. Have you ever tried to cut down your drinking / drug use / gambling? Y / N

2. Have you ever thought that you had a problem with alcohol, drugs, or gambling? Y / N

3. Have you ever had negative consequences after drinking, using or gambling? Y / N

4. Has anyone ever suggested you have a problem with alcohol, drugs or gambling? Y / N

5. Have you ever used more than you intended to use or spent more than you intended? Y / N

IF THE ANSWER TO ANY OF THE ABOVE IS YES, PLEASE COMPLETE THIS SECTION. IF NOT, SKIP TO MEDICATION SECTION.

Drug	Age of First Use	Last Use	Amount of Use	Frequency of Use	Route of Administration	Consider it a problem?
Alcohol						
Marijuana						
Cocaine						
Heroin						
Prescription Drugs						
Other						

Previous Treatment for Substance Abuse

Date	Who / Where	Type of Program	Outcome/Sobriety

Longest Period of Sobriety: ________________ Longest Period of gambling absence: _______________

Have you ever harmed yourself while under the influence? Y / N

Have you ever harmed anyone else while under the influence? Y / N

Age first gambled? ________________ Most you've ever lost gambling? _________________________

How much technology/social media do you engage in per day or week? E.g. gaming, social media, etc: ________

____

Mental Health History: Have you been diagnosed with any mental condition or biochemical imbalance?

____

What is your history of physical, sexual, verbal or emotional abuse? ______________________________

____

____

____

Are you a victim of a crime which has been reported to the police? ☐ Yes ☐ No ☐ Unsure

If yes, has an application Crime/Victims Assistance been submitted? ☐ Yes ☐ No

Have you ever attempted suicide? If so, please provide more info (e.g. number of attempts, age, circumstances)

____

____

____

History of Mental Health Treatment – Inpatient

Date	Hospital	Reason for Admission	Length of Stay

Total number of psychiatric hospitalizations: __________

History of Mental Health Treatment – Outpatient

Date	**Who / Where**	**Reason for Seeking Services**	**Outcome or Benefit**

Current Therapist/Healers **Type of Care**

____ ___________________________

____ ___________________________

____ ___________________________

Is there any other information that you think might be helpful in order to understand you and your needs better?

____

____

____

____

I certify that the responses are correct to the best of my knowledge. I agree to inform my clinician should my physical or mental condition change.

____ ________________

Client Signature Date

____ ________________

Parent/Guardian Signature Date