Feda Shawwa M.S., LPC

INDIVIDUAL CLIENT INTAKE FORM

Date: ___________

Name: ____ Age: ____________

Address:____

____

City/State/Zip: ____

Home Phone Number: ______________________________ Message OK here? _________

Work Phone Number: ______________________________ Message OK here?_________

Email: _____________________________________ Message OK here?____________

Additional Numbers: ____

Emergency Contact: ____

How did you hear about me?

☐ www.psychologytoday.com

☐ www.theravive.com

☐ www.goodtherapy.com

☐ Referred by: ____

☐ Other ____

Relationship Status:

Single ☐ Married ☐ Separated ☐ Divorced ☐

Widowed ☐ Cohabiting ☐ Other ☐

Partner's Name: ____ Age: ___________

Primary Household:

Name	**Relation**	**Age**	**Sex**

Family Members To Be Involved In Counseling: ________________________________

____

CLIENT'S HEALTH

Primary Care Physician:

____
Name Phone

Physical Disability: Yes No (If yes, explain)

____

Chronic Illness: Yes No (If yes, explain)

____

Terminal Illness: Yes No (If yes, explain)

____

What medication are you currently taking?

Medication	Dosage	Purpose

Have you ever seen or contemplated seeing a mental health professional (psychiatrist, psychologist, or a counselor)? Yes No

If yes: Previous Mental Health Agency or Therapist ___________________________________

Dates of Service__________________________ (beginning - ending)

Have you ever been hospitalized for mental health concerns? Yes No

If yes: When ____

Where____

FAMILY HISTORY/EXPERIENCES

Current Family Stressors:

- ☐ Chronic illness of family member
- ☐ Death of significant person
- ☐ Domestic Violence
- ☐ Family member absent
- ☐ Family member's disability/major accident/illness
- ☐ Family member emotional problems
- ☐ Family member suicide
- ☐ Financial problems
- ☐ Moved a lot
- ☐ Frequent Arguing
- ☐ Divorce
- ☐ Other ____

History of emotional/behavioral problems: Yes No
(If yes, please explain)

____

History of alcohol/drug/substance abuse: Yes No
(If yes, please explain)

____

History of family violence: Yes No
(If yes please explain)

____

History of criminal activity: Yes No
(If yes, please explain)

____

CURRENT CONCERNS

Please mark the following items that apply.

- ☐ Abuse (physical, emotional, sexual)
- ☐ Adjustment to life changes (moving, getting married or divorced, aging, etc.)
- ☐ Drug or alcohol use (both legal and illegal drugs)
- ☐ Eating problem (purging, bingeing, overeating, hoarding, severely restricting diet)
- ☐ Family or Stepfamily relationship problems
- ☐ Feeling angry or irritable
- ☐ Feeling anxious (nervous, clingy, fearful, worried, panicky, obsessive-compulsive, lacking trust, etc.)
- ☐ Feeling sadness or depression NOT related to grief
- ☐ Feeling sadness or depression related to grief
- ☐ Health concerns (physical complaints and/or medical problems)
- ☐ Illegal behaviors (runaway, stealing, fire setting, truancy, etc.)
- ☐ Non-family relationship problems (co-workers, peers, etc.)
- ☐ Parent-Child relationship (discipline, adoption, single parent, etc.)
- ☐ Sexual concerns (loss of interest, excessive masturbation, inappropriate acting out)
- ☐ Sleep problem (nightmares, sleeping too much or too little, etc.)
- ☐ Suicidal Ideation (thoughts of death, wanting to die)
- ☐ Unusual behavior (bizarre actions, speech, compulsive behavior, tics, motor behavior problems, etc.)
- ☐ Other ____

ALCOHOL & SUBSTANCE USE INFORMATION

How often and **how much** do you consume alcoholic beverages?

____

Do you smoke marijuana or use other "street drugs" (please remember this information is strictly confidential).

____

Briefly describe the problem that has brought you to therapy

____

____

What are your goals of therapy?

____

____

____

FOR INSURANCE REIMBURSEMENT

Primary Insurance Name: ____

Primary Insurance Address: ____

Primary Insurance City/State/Zip: ____

Patient's Birth Date: ____

Patient's Name: ____

Employer Name: ____

ID Number: ___________________________ Group Number: _____________________

Name of Insured: ____

Insured's Birth Date: ____

Employer Name: ____

ID Number: ___________________________ Group Number: _____________________

Is an EAP or referral form required/involved? __________________________________