CLIENT INTAKE

Lynne Murray Watkins, MSW, LCSW

Please answer the questions below and bring this form to your session. Please note: the information you provide here is protected as confidential information.

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

Birth Dt:_____ Age:_____ Gender: M F

St Address_____

City/State_____ Zip_____

Home Ph:_____ May I leave a message? Y N

Cell/Other ph:_____ May I leave a message ? Y N
May I leave a text? Y N

Email(optional):_____
(Note: Email and text correspondence is not considered confidential communication.)

Occupation:_____Employer:_____

Marital Status: ___Never Married ___Domestic Partnership ___ Married
___Separated ___Divorced ___Widowed

If applicable, names and ages of spouse/children:_____

_____

Currently living with _____

Referred by (if any):_____

Emerg Contact:_____Rel:_____Ph:_____

Health History

Previously received mental health services (psychotherapy, psychiatric care, etc)? Y N
If yes, please list therapist/practitioners and dates:

_____ _____

_____ _____

Current Medications Dosage Prescribing Physician Reason

_____

_____

_____

_____

How would you rate your current physical health? _____

Please list any specific health problems_____

_____

How would you rate your current sleeping habits? _____

Please list any specific sleep problems:_____

How many times a week do you exercise? _____

What types?_____

Please list any appetite/eating problems you are experiencing_____

_____

Are you currently experiencing significant sadness, grief, or depression? Y N

If so, for how long?_____

Are you currently experiencing anxiety, panic attacks, or have any phobias? Y N

If so, when did this begin?_____

Are you currently experiencing any chronic pain? Y N

If so, please describe:_____

Do you have difficulty getting along with others? Y N

If so, in what ways?_____

Are you in a romantic relationship? Y N For how long?_____
How would you rate your relationship (1 – 10)? _____

Do you consider yourself to be spiritual or religious? Y N Somewhat
Were you raised in a spiritual/religious environment? Y N
Are you affiliated with a religious group? Y N _____

Are you currently involved in any legal cases (traffic, civil, criminal)? Y N

If yes, please describe:_____

Are you experiencing stresses or problems at work? Y N If so, please describe:

_____

What other significant life changes or stressful situations have you experienced recently? Please describe:

_____

_____

What do you hope to achieve in therapy?_____

_____

Family History

In the following section, please identify if there is a family history of any of the following. If yes, indicate the family member(s) relationship to you.

Alcohol/Substance Abuse	Y	N	_____
Other addictive behaviors	Y	N	_____
Anxiety	Y	N	_____
Attention Deficit Disorder	Y	N	_____
Chronic illness	Y	N	_____
Depression	Y	N	_____
Domestic Violence	Y	N	_____
Eating Disorders	Y	N	_____
Obsessive Compulsive Disorder	Y	N	_____
Schizophrenia	Y	N	_____
Suicides or Attempts	Y	N	_____

Are there unusual, or traumatic, circumstances that affected your childhood development?
Y N If yes, please describe:_____

_____

Has there been a history of child abuse? Y N Child Neglect? Y N
If yes, what type? ___Physical ___Sexual ___Verbal ___Emotional

Other childhood issues:_____

_____

Substance Use History
Check any of the following that you have used, when you first used and when you stopped, if so:

_____ Alcohol Frequency_____Began_____Stopped_____
_____Caffeine _____
_____Heroin/Opiates _____
_____Marijuana _____
_____Cocaine _____
_____Nicotine _____
_____Barbituates _____
_____Inhalants _____
_____Hallucinogens _____
_____Other_____ _____

Have you ever felt you should cut down on your alcohol/drug use?	Y	N
Have others expressed concern about your alcohol/drug use?	Y	N
Have you missed school or work due to your alcohol/drug use?	Y	N
Have you had legal consequences from your alcohol/drug use?	Y	N
Have you ever tried to stop using alcohol/drugs?	Y	N
Are you currently or have you been in a relationship with someone who abuses or has abused drugs/alcohol? Please describe:	Y	N

_____

Other substances/activities that you may abuse, ie: food, work, spending, internet, exercise, gambling, sex, etc) : _____

_____

Thank you for using my office. I look forward to working with you.