Mind Body Therapeutics LLC - Client Intake Form (Confidential)

* Please take the time to complete these forms fully, it will save everyone valuable time.

Today's Date:_________________ ID provided: Y / N ________ DSM 5:_______________(Office)

Client's Name:________________________________ Date of Birth:_______________________

Address:____________________________________ City/State/Zip:___________________________

Home phone:________________________________ Work phone:___________________________

Occupation:________________________________ Employer:____________________________________

# of Years_____________________Previous Occupation:_________________ Dates:________________

Educational/Career Aspirations: ____

Sexual Preference/Identity: ____

Marital/CU Status: ____________________________ # of Marriages: _________ Years:_________________

Date(s) of Divorce or Separation: __________________ # of children:__________

Name(s)/Age(s) of Child(ren):____

Closest Relative & Name: ___________________________________Phone:___________________________

Parents Name:____ Ethnicity:__________________________

Parents Occupation:______________________________________ Ages:_____________________________

# of Siblings: ____ Name(s)/Age(s):____

Family History:

Illnesses: ____

Deaths: ____

Challenges:____

Birthplace:____

Present Religious Affiliation:____

Previous Affiliation:____

Have you ever had any illness?____

Have you ever been hospitalized?____

Where were you hospitalized?____

Have you ever had therapy?____

Name of Therapist(s):____

Details: ____

Dates: ____

Physicians Name:____

Physician's Address:____

City/State/Zip:____

Date of last physical:____

Present Health: Poor/Fair/ Good

Who referred you: _____________________________ Reason: ____________________________

Mood Symptom Checklist: Please complete all that apply

Depression:	How often:___ times per day/week/month
Anxiety:	How often:___ times per day/week/month
Hopelessness:	How often:___ times per day/week/month
Irritability:	How often:___ times per day/week/month
Mood changes:	How often:___ times per day/week/month
Sadness:	How often:___ times per day/week/month
Excited/intense energy:	How often:___ times per day/week/month
Anger/rage:	How often:___ times per day/week/month
Overwhelming feelings of guilt	How often: ___ times per day/week/month
Shame & difficulty enjoying life:	How often: ___ times per day/week/month

Current medications you are taking:

Medication: ______________ Dosage: ______ Frequency: ______ Prescribing Physician: ________________

Medication: ______________ Dosage: ______ Frequency: ______ Prescribing Physician: ________________

Medication: _______________Dosage: ______ Frequency: ______ Prescribing Physician:________________

Other: ____

Interpersonal Relations: Please expand where necessary

- Increased conflict with others/increased family conflict:____

____

- Difficulty making or keeping friends/relationship issues:____

____

- Socially withdrawn/isolated:____

____

Increased sexual problems/impotence:____

____

- Concerns/increased social anxiety:____

____

- Problems with intimacy:____

____

- Increased difficulty tolerating others/Trouble with the law/authority figures:____________________________

____

Behaviors: Please expand where necessary

- Hurting yourself How often:___ times per day/week/month
- Doing the same thing repeatedly/Social isolation:____

____

- Uncontrolled spending or gambling increased use of alcohol and/or drugs:__________________________

____

- Reckless behavior/impulsivity:____
- Over Ambitious:____
- Increased financial concerns:____

Thinking About:

- Academic/work/Partner problems: How often: ____ times per day/week/month
- Intrusive negative thoughts: How often: ____ times per day/week/month
- Flashbacks: How often: ____ times per day/week/month
- Irrational fear or anxiety: How often: ____ times per day/week/month
- Racing thoughts: How often: ____ times per day/week/month
- Paranoia: How often: ____ times per day/week/month
- Easily distracted/concentration problems: How often: ____ times per day/week/month
- Thinking the same thoughts repeatedly: How often: ____ times per day/week/month
- Memory problems: How often: ____ times per day/week/month

- Low self-esteem: How often: ____ times per day/week/month
- Worries about body-image: How often: ____ times per day/week/month
- Confusion: How often: ____ times per day/week/month
- Seeing/hearing things that aren't there: How often: ____ times per day/week/month

–Unmotivated/Trouble getting out of bed: How often: ____ times per day/week/month

-Thoughts of wanting to take your own life: How often: ____ times per day/week/month

-Thoughts of wanting to hurt someone else: How often: ____ times per day/week/month

Physical:

- Increased sleep duration: How often: ____ times per day/week/month
- Decreased sleep duration: How often: ____ times per day/week/month
- Disturbing nightmares/dreams How often: ____ times per day/week/month
- Panic/anxiety How often: ____ times per day/week/month
- Increased appetite/weight gain: How often: ____ times per day/week/month
- Decreased appetite/weight loss How often: ____ times per day/week/month
- Agitation/restlessness: How often: ____ times per day/week/month
- Unusual sensory experiences (smell, taste) How often: ____ times per day/week/month
- Headaches: How often: ____ times per day/week/month
- Rapid heart rate/Numbness or tingling pain: How often: ____ times per day/week/month
- Tearfulness: How often: ____ times per day/week/month
- Fatigue: How often: ____ times per day/week/month
- Palpitations: How often: ____ times per day/week/month
- Vomiting: How often: ____ times per day/week/month
- Tremors: How often: ____ times per day/week/month
- Dizziness: How often: ____ times per day/week/month
- Fainting Spells: How often: ____ times per day/week/month

Other physical problems, please specify:____

____

- What are you Drinking Habits: ____ Drinks per Day/Week/Month
- Have you ever had a termination of pregnancy? ___Yes ___No When: __________________
- Have you ever had any head injuries? ___Yes ___No When:__________________
- Have you ever been diagnosed with PTSD ___Yes ___No When: __________________

* Descriptions for the above: ____

- Have you been involved in Domestic Violence? ___Yes ___No When: __________________

- Have you ever had a Physical, Emotional or Sexual Abuse experience: ___Yes ___ No When: ___________

Medical History: Please list any surgeries, chronic illnesses and/or medical conditions you may have had:

____

____

Medical History: Please list any surgeries, chronic illnesses and/or medical conditions in your family history:

____

____

Please describe your living conditions with your significant other/spouse, children, pet & family:_____________

____

____

Current Job Situation: employed/satisfied/Dissatisfied/relationships at work:

____

____

1. What do you consider to be some of your strengths?

____

2. What do you consider to be some of your weaknesses?

____

3. What would you like to accomplish out of your time in therapy? Some goals?

____

____

4.Do you have an interest in learning about a healthier lifestyle?

____

Other:____

* Your signature indicates that you place no limitations in history of illness or diagnostic/therapeutic information including any and all treatment for substance abuse, psychiatric disorders and medications.

Name ____________________________ **Signature:**__________________________ **Date:**______________

Parent/Guardian Name:______________________ **Signature:**__________________ **Date:** _____________