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:_____ License on file: ____ (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: _____

Marital 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- Socially withdrawn/isolated:_____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 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?

_____

_____

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:** _____