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MENTAL HEALTH PROVIDER SERVICES

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New Client Intake Form

Client Information

Name: _____ DOB:_____

Address: _____

Client's Telephone (cell): _____ (home):_____

(work): _____

Can I leave a message at your? ☐ Home ☐ Work ☐ Cell

Emergency Contact

Name: _____

Address: _____

Telephone Numbers: _____

Relationship to Client: _____

I accept cash, check, and credit card. There is a $3.00 processing fee for credit cards. If you would like to use a credit card please check here agreeing to the sending and receiving of your payment information through the Internet application 'Square Inc.' [square.com]. ☐

How did you hear about me? Who / what referred you?

_____

What are your goals or intentions in seeking support?

_____

_____

_____

_____

_____

_____

Have you received other types of therapy for this?

_____

_____

Please describe in detail your current condition, your symptoms and their frequency. Note any time of day/night when it is worse, any patterns you notice around what may trigger it (stress, emotional upset, lack of sleep, eating certain foods, environments, exercise, family, relationships, etc.)

_____

_____

_____

_____

Please list any major accidents, surgeries, major injuries, intense relationships, or any especially difficult experiences you've had in your life. Please list approximate dates as well:

_____

_____

_____

_____

_____

Please list medications, supplements, and other substances you are taking and what you're taking them for:

_____

_____

_____

Do you smoke? ☐Yes ☐ No If yes, what kind, how much/month?_____

Do you experience any of the following?

☐Yes ☐ No **Headaches** or migraines

☐Yes ☐ No Back pain

☐Yes ☐ No Jaw pain or clicking

☐Yes ☐ No Vision issues

☐Yes ☐ No Nightmares

☐Yes ☐ No Digestive issues

☐Yes ☐ No Difficulty hearing

☐Yes ☐ No Do you grind your teeth at night?

☐Yes ☐ No Do you ever have trouble: ☐ falling asleep / ☐ staying asleep?

If you checked yes to any, please explain in the space below: (location, frequency and duration, etc.) _____

_____

_____

Have you experienced any of the following within the last three years?

☐ Hospitalization ☐ Heart problems (Do you have a pacemaker? ☐Yes ☐ No)

☐ Stroke ☐ High blood pressure

☐ Cancer ☐ Fibromyalgia

☐ Disc problems ☐ Sciatica

☐ Arthritis ☐ Carpel tunnel / Repetitive strain injury

☐ Whiplash ☐ Insomnia

☐ Allergies ☐ Skin Problems

☐ Other

If you checked yes to any, please explain in the space below: _____

_____

_____

Are you currently undergoing stress or going through an emotionally strenuous period in your life? If so, what are you doing to manage it? ☐Yes ☐ No

_____

_____

_____

How would you rate your current level of stress? (9 is the highest): 0 1 2 3 4 5 6 7 8 9

Have there been any losses or big changes recently in your life? (ie: living situation, work, family, or relationship) ☐Yes ☐ No

_____

_____

_____

What brings you the most joy, ease, inspiration, or sense of belonging in your life?

_____

_____

_____

Do you have any animal critter friends in your life? ☐Yes ☐ No _____

Do you have any kind of mind/body practice? (yoga/meditation/martial arts/time in nature, etc.,)

_____

_____

_____

What do you do for exercise?

_____

_____

If you know about your birth process please share any info you can, any complications or medical interventions, as well as what was going on in your family emotionally or psychologically.

_____

_____

_____

_____

_____

_____

Is there anything else you would like me to be aware of, that may allow me to provide you with the best possible support?

_____

_____

_____

_____

_____