Client Intake Form

Please provide the following information below needed for our records. All information will be held confidential in your client file. ***If there are questions that you do not wish to answer at this time, feel free to leave them blank****. Please bring the completed form with you to your first session or email a copy prior to your appointment.*

Name:

_____

(Last) (First) (Middle initial)

Name of parent or guardian (if under 15 years old):

_____

(Last) (First) (Middle initial)

Age: _____ Birthdate: _____ Gender: ___ M ___ F

Marital Status: ___ Never Married ___ Married ___ Divorced ___ Separated

___ Widowed ___ Domestic Partnership

Please list any children and ages: _____

Home Address: _____

(Street Number)

_____

(City) (State) (Zip Code)

Home Phone: _____ ____ yes ____ no

(okay to leave a message)

Cell/Other Phone: _____ ____ yes ____ no

(okay to leave a message)

Email: _____ ____ yes ____ no

please note that email is not always considered confidential (okay to email)

How did you find out about Jason Lavalle, LICSW: _____

Referred by (if any): _____

Emergency Contact Information:

_____

(Name) (Relation) (Phone #)

Have you previously received any type of mental health services, such as counseling or psychiatric services: ___ yes ___ no

If yes:

_____

(Name) (Phone)

Health and Medical

Please list current and past prescription psychiatric medication that you are taking or have taken, including dose and frequency:

_____
_____
_____
_____

How would you describe your current physical health (please circle one):

Poor Unsatisfactory Satisfactory Good Excellent

Please list any current medical conditions:

_____
_____
_____

Are you having any trouble with your sleeping or eating patterns (if so, please describe):

_____
_____
_____

Please check from the following list any items that you have experienced recently:

___ Loss of interest in previously enjoyed activities
___ Overwhelming sadness

___ Crying often
___ Feeling hopeless
___ Overwhelming anxiety, panic, or worry
___ Frequent physical complaints (headaches, etc)
___ Significant change in weight
___ Trouble falling asleep or staying asleep at night
___ Racing or disorganized thought patterns
___ Thoughts of suicide
___ Irritability or anger
___ Mood shifts
___ Self Mutilation
___ Overindulgence in alcohol, recreational drugs, or sexual activity

Family History
Please list any mental health conditions that exist within your family, as well as the family member with the condition:
_____
_____
_____

Is there a history of drug/alcohol abuse and addiction in your family? If so, please describe:
_____
_____

Is there any history of suicide in your family? If so, please list:
_____

Do you have any siblings? If so, please list with ages:
_____

Who do you turn to for support in your family?
_____

Occupational and Social
Are you currently employed? ____ yes ____ no

If yes, what is your current occupation:
_____

Do you enjoy your current profession? ____ yes ____ no

If no what would you change:
_____

Please list any current legal troubles at this time, if any:
_____
_____
_____

What kind of activities or coping strategies do you use when you are stressed or overwhelmed?
_____
_____
_____

What do you view to be your strengths as a person?
_____
_____
_____

Briefly describe what has brought you to therapy at this time and what goals you would like to accomplish during therapy.
_____
_____
_____
_____
_____
_____
_____
_____