Connecting The Pieces, Inc

816-921-0971

Client Intake Form

Please fill out this biographical background form as completely as possible. It will help me in our work together. Information is confidential as outlined in the Office Policy form and the HIPAA Notice of Privacy Practices. If you do not desire to answer any question, merely write, "Do not care to answer." Please print or write clearly and bring this form with you to the first session. Thank You!

NAME: _____ MALE/FEMALE: _____ DATE: _____
DATE OF BIRTH: _____ AGE: _____
ADDRESS: _____ _____
TELEPHONE: H: _____ Cell: _____
W/Off: _____ _____FAX: _____
Okay to leave a phone message? Yes_____ No_____
E-mail: _____
Okay to contact/send mailings to you via email? Yes_____ No_____
Please briefly describe the reason you are seeking counseling services at this time
_____
_____
_____
_____
_____
_____
_____
_____
_____
HIGHEST GRADE completed in school: _____ _____
ETHNIC ORIGIN_____ FIRST LANGUAGE _____
PERSON & PHONE NUMBER TO CALL IN EMERGENCY: _____
How did you find out about my services? _____
OCCUPATION (former if retired): _____
IF UNEMPLOYED – FOR HOW LONG/REASONS?
_____
CIRCLE THAT WHICH APPLIES:
MARRIED/SINGLE/DOMESTIC PARTNERED/DIVORCED/SEPERATED/WIDOWED
NUMBER OF CHILDREN IF ANY_____ _____
NAME OF SPOUSE/PARTNER _____
RELIGIOUS/SPIRITUAL AFFILIATIONS_____

Estimate the severity of your problem: PLEASE CIRCLE:
Mild-Moderate-Severe-Very severe
MEDICAL DOCTOR (name /phone): _____
Okay to contact your medical doctor to assure coordination of care? Yes_____ No___
PAST/PRESENT MEDICAL CARE (major medical problems, surgeries, accidents, falls, illness):

SPECIFY MEDICATION you are presently taking and for what. PRINT clearly:

PAST/PRESENT DRUG/ALCOHOL USE/ABUSE (AA, NA, treatments)**:**

SUICIDE ATTEMPT/S or **VIOLENT BEHAVIOR** (describe: ages, reasons, circumstances, how, etc)_____

PLEASE LIST ANY PRIOR MENTAL HEALTH DIAGNOSIS AND ANY RELEVANT FAMILY HISTORY: _____

PAST/PRESENT PSYCHOTHERAPY (specify: month year/s (beginning—end), estimated no. of sessions, name of therapist, degree, phone & address, initial reason for therapy, Ind/Couple/Family, medication, brief description of the relationship and how helpful it was, and how/why it ended)**:**

PLEASE LIST PREVIOUS PSYCHIATRIC HOSPITALIZATIONS – INCLUDE DATES AND REASON FOR ADMISSION(S) _____

ARE YOU CURRENTLY RECEIVING COUNSELING FROM ANOTHER THERAPIST? _____
IF YES, PLEASE PROVIDE THE NAME OF YOUR CURRENT THREAPIST AND PHONE NUMBER AND REASON FOR TREATMENT: _____

DESCRIBE YOUR CHILDHOOD IN GENERAL (Relationships with parents, siblings, others, school, neighborhood, relocations, any school/behavioral/problems, abusive/alcoholic parent):

IF PARENTS DIVORCED: Your age at the time: _____, Describe how it affected you at the time _____

FAMILY HISTORY OF ALCOHOLISM, MENTAL ILLNESS, OR VIOLENCE (including suicide, depression, hospitalizations in mental institutions, abuse, etc.):

ARE YOU INVOLVED IN ANY CURRENT OR PENDING CIVIL OR CRIMINAL LITIGATION/S, LAWSUIT/S OR DIVORCE OR CUSTODY DISPUTES? (If you answer Yes, please explain

Please discuss your relationship to technology – do you use social networking like Face book, texting? If so how much and indicate if it is a problem for you at this time

Please describe what you would like to achieve from counseling services (we will talk more about treatment goals once counseling has started):

Please include any additional information you would like me to know about you and your situation:

Client signature_____ **Date**_____

Please complete this form and bring it with you to the session.
Thank You!