SEED OF HOPE COUNSELING SERVICES, PLLC

Gateway Executive Suites, 4140 E. Baseline Rd, Suite 101, Mesa, AZ 85206 ph: 480.455.0915 fx: 480.545.2260

CLIENT INTAKE FORM

Welcome to my counseling practice! Please provide the following information for our records. The information that you provide will be used for our first counseling session and is held to the same standards of confidentiality as our therapy sessions. Please print out this form and bring it with you or allow yourself at least 30 minutes prior to your appointment to complete the form in the office.

PATIENT INFORMATION

_____ _____ _____

LAST NAME FIRST NAME MIDDLE INITIAL

_____ _____ _____

LAST NAME OF PARENT / GUARDIAN (IF YOU ARE A MINOR) FIRST NAME MIDDLE INITIAL

_____ _____ _____

DATE OF BIRTH AGE GENDER

MARITAL STATUS: (CIRCLE ONE) NEVER MARRIED MARRIED SEPARATED DIVORCED WIDOWED

_____

NUMBER OF CHILDREN:

_____

STREET ADDRESS

_____ _____ _____

CITY STATE ZIP

_____ May we leave messages identifying our office? YES NO

HOME PHONE

_____ May we leave messages identifying our office? YES NO

CELL PHONE

_____ @ _____

EMAIL ADDRESS

May we email you? *Please be aware that email may not be confidential. YES NO

Whom were you referred by: _____

Are you currently receiving psychiatric services, professional counseling, or psychotherapy elsewhere? YES NO

Have you had previous psychotherapy? NO If YES, please list therapist's name: _____

Are you currently taking prescribed psychiatric medication (anti-depressants or others)? YES NO

If YES, please list: _____

HEALTH AND SOCIAL INFORMATION

1) How is your physical health at present? (please circle)

POOR UNSATISFACTORY SATISFACTORY GOOD VERY GOOD

2) Please list any persistent physical symptoms or health concerns (i.e., chronic pain, headaches, hypertension, diabetes, etc.):

_____

3) Are you having any problems with your sleep habits? YES NO

If YES, circle where applicable: Sleep too little Sleep too much Poor quality sleep Disturbing dreams

Other: _____

4) How many times per week do you exercise? _____ How long each time? _____

5) Are you having any difficulty with appetite or eating habits? YES NO

If YES, check where applicable: Eating less Eating more Binging Restricting

Have you experienced significant weight change in the last 2 months? YES NO

6) Do you regularly use alcohol? YES NO

If YES, in a typical month, how often do you have 4 or more drinks in a 24-hour period? _____

7) How often do you engage in recreational drug use? (please circle) Daily Weekly Monthly Rarely Never

8) Have you had suicidal thoughts recently? (please circle) Frequently Sometimes Rarely Never

Have you had them in the past? (please circle) Frequently Sometimes Rarely Never

9) Are you currently in a romantic relationship? YES NO

If YES, how long have you been in this relationship? _____

On a scale of 1-10, how would you rate the quality of your current relationship? _____

10) In the last year, have you experienced any significant life changes or stressors: _____

_____

Have you ever experienced?	Please Circle One	
Extreme depressed mood?	NO	YES
Wild mood swings?	NO	YES
Rapid Speech?	NO	YES
Extreme Anxiety?	NO	YES
Panic Attacks?	NO	YES
Phobias?	NO	YES
Sleep Disturbances?	NO	YES
Hallucinations?	NO	YES
Unexplained losses of time?	NO	YES
Unexplained memory lapses?	NO	YES
Alcohol / Substance abuse?	NO	YES
Frequent body complaints?	NO	YES
- Eating disorder?	NO	YES
Body Image Problems?	NO	YES
Repetitive Thoughts (i.e., obsessions)	NO	YES
Repetitive Behaviors (i.e., frequent checking)	NO	YES
Homicidal thoughts?	NO	YES
Suicide attempt?	NO	YES

OCCUPATIONAL INFORMATION

Are you currently employed? YES NO

If YES, who is your current employer / position? _____

If YES, are you happy at your current position? _____

Please list any work-related stressors, if any: _____

FAMILY MENTAL HEALTH HISTORY

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (circle any that apply and list family member, i.e., sibling, parent, uncle, etc.)

DIFFICULTY			FAMILY MEMBER
Depression	NO	YES	_____
Bipolar Disorder	NO	YES	_____
Anxiety Disorders	NO	YES	_____
Panic Attacks	NO	YES	_____
Schizophrenia	NO	YES	_____
Alcohol / Substance Abuse	NO	YES	_____
Eating Disorders	NO	YES	_____
Learning Disabilities	NO	YES	_____
Trauma History	NO	YES	_____
Suicide Attempts	NO	YES	_____

OTHER INFORMATION

What do you consider to be your strengths?

_____

_____

What do you like most about yourself?

_____

_____

What are effective coping strategies that you've learned?

_____

_____

What are your goals for therapy?

_____