Openings Counseling LLC

Client Intake Form

Please provide the following information and answer the questions below completely to the best of your ability and bring this form to your first session. Information you provide here is protected as confidential information.

Name: _____

Name of parent/guardian (if under 18 years): _____

Birth Date: _____ Age: _____ Gender: □ Male □ Female

Contact Information

Home Phone: _____ May I leave a message? □Yes □No

Cell/Other Phone: _____ May I leave a message? □Yes □No

E-mail*: _____ May I email you? □Yes □No

**Please note: Email correspondence is not considered to be a confidential medium of communication.*

Address: _____

_____
(City) (State) (Zip)

Emergency Contact Information: _____ _____
Name, relationship to client Phone number

Marital Status:

□ Never Married □ Domestic Partnership □ Married

□ Separated □ Divorced □ Widowed

Please list any children/age: _____

_____

_____

Referred by (if any): _____

Susan Scott MS, LMFT **OpeningsCounseling@gmail.com** **(860) 510-3310**

Coordination of Treatment : If referred by a physician or medical professional, may I contact that person to inform them of your beginning treatment with me? __Y __N Permission is granted to inform the referring physician that I am being treated.

Name of referring professional: _____ Phone_____

Address:_____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, counseling, etc.)? □ No □Yes, previous therapist/practitioner(s):

_____

Please list any other complementary medicine providers. (ie chiropractor, naturopath, acupuncturist, massage therapist, etc). _____

_____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

To better assess your needs, **please rate how stressful/not stressful each of the following the areas** in your life are on a scale from 1-10 (1=not stressful, 10= very stressful),

Rating

_____ **Physical:** Aches, pains, discomfort, medical disorders, others:

_____

Please list any health problems you are currently experiencing: _____

_____

Are you currently experiencing any chronic pain? □ No □Yes If yes, please describe?

_____

How many times per week do you generally exercise? _____

What types of exercise to you participate in? _____

_____ **Mental** : Worries, irrational thoughts, distracted, others:_____

_____

Are you currently experiencing anxiety, panic attacks or have any phobias? □ No □Yes

If yes, when did you begin experiencing this? _____

_____ **Emotional :** Angry, sad, numb, overall not enough joy, others: _____

Are you currently experiencing overwhelming sadness, grief or depression? □ No □Yes

If yes, for approximately how long? _____

Susan Scott MS, LMFT **OpeningsCounseling@gmail.com** **(860) 510-3310**

What significant life changes, losses, or stressful events have you experienced recently? _____

_____

Do you currently, or have you ever had suicidal or homicidal thoughts? □ No □Yes

If yes, □ Suicidal □ Homicidal

If yes, have you thought about how you would do this? □ No □Yes

If yes, do you have the means to do this? □ No □Yes

If yes, do you have the intent? □ No □Yes

Do you have people to call if you are struggling? □ No □Yes

If so, who? _____

_____ **Relational:** Difficulties with interpersonal relationships _____

Are you currently in a romantic relationship? □ No □Yes If yes, for how long? _____

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

_____ **Self :** Low self-esteem, guilt, feeling not good enough _____

_____ **Spiritual:** Do you consider yourself to be spiritual or religious? □ No □Yes

If yes, describe your faith or belief(s): _____

_____ **Work :** Job burnout, performance anxiety, coworker, discord _____

Are you currently employed? □ No □Yes

If yes, what is your current employment situation: _____

Do you enjoy your work? Is there anything stressful about your current work? _____

_____

_____ **Nutritional :** Over/under eating, not able to stick to healthy changes? _____

_____

Susan Scott MS, LMFT **OpeningsCounseling@gmail.com** **(860) 510-3310**

Please list any difficulties you experience with your appetite or eating patterns. _____

_____

_____ **Sleep :** Please complete the following section regarding your sleep patterns.

How many hours, on average, are you sleeping each night? _____

On a scale from 1-10 (1=poor, 10=excellent), rate your quality of sleep:_____

Please describe your current night time routine. _____

_____

Do you wake up throughout the night? Please describe what happens if you wake up during the night :

_____

_____

Times/night:_____ Days/wk:_____ How long has this been a problem for you?

_____

We all have stress in our lives; please describe the strategies you presently use to manage stress:

Daily: _____

Weekly: _____

Monthly: _____

Yearly: _____

On a scale from 1-10 (1=not effective, 10= very effective), how well do these coping strategies work for you?

_____ What could you be doing better? _____

_____

Please list the top stressors affecting you at this time: _____

_____

Are you currently taking any prescription medication? □Yes □ No

Please list any medications you are currently taken or have taken in the last 6 months, along with the reasons you are taking them: _____

_____

Susan Scott MS, LMFT **OpeningsCounseling@gmail.com** **(860) 510-3310**

Have you ever been prescribed psychiatric medication? □Yes □ No

Please list any medications you are currently taken or have taken in the last 6 months, along with the reasons you are taking them:

_____

Do you have more than one alcoholic drink more than once a week? □ No □Yes If yes, how much do you drink daily/weekly? _____

What do you typically drink? _____

How often do you engage recreational drug use? □ Daily □Weekly □ Monthly □ Infrequently □ Never

What types of drugs are you presently using or have used in the last 6 months? _____

_____

PERSONAL AND FAMILY HISTORY INFORMATION

In the section below identify if there is personal and/or family history of any of the following. If you have a history of any of the items listed below, please circle yes, and put a check in the column entitled, "self." If a family member has a history of any of the items listed below, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

Please Circle	**Self**	**List Family Member**
Alcohol/Substance Abuse yes/no	_____	_____
Anxiety yes/no	_____	_____
Depression yes/no	_____	_____
Domestic Violence yes/no	_____	_____
Eating Disorders yes/no	_____	_____
Obesity yes/no	_____	_____
Obsessive Compulsive Behavior yes/no	_____	_____
Schizophrenia yes/no	_____	_____
Suicide Attempts yes/no	_____	_____
Sexual Abuse yes/no	_____	_____

How would you say your childhood or upbringing impacted who you are today? _____

_____

_____

_____

Susan Scott MS, LMFT **OpeningsCounseling@gmail.com** **(860) 510-3310**

ADDITIONAL INFORMATION

What types of coping skills are you interested in incorporating into your life? *(circle all that apply)*

Relaxing Breathing Techniques	Developing an exercise routine
Energizing Breathing Techniques	Walking
Guided Imagery/Visualization	Acupuncture
Meditation	Massage
Taking a Yoga class	Other _____

What do you consider to be some of your strengths? _____

_____

_____

What do you consider to be some of your weakness? _____

_____

_____

What would you like to accomplish from your time in therapy? _____

_____

_____

What will be your personal indicators to know that your efforts and therapy have been successful? _____

_____

_____

Is there anything else that you would like me to know at this time? _____

_____

_____

_____

Susan Scott MS, LMFT **OpeningsCounseling@gmail.com** **(860) 510-3310**