CLIENT INTAKE FORM

Guilaine Bell

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Date of first appointment:

Please take your time in providing the following information. The questions are designed to help me begin to understand you so that our time together can be as productive as possible. All information provided is confidential.

Referred by:
□ Medical Provider:
☐ Insurance Provider:
☐ My Website: restcnc.com
☐ PsychologyToday
□ Friend/Family:
□ Other:
Have you previously received any type of mental health services?
□ Yes
□No
If yes, which of the following:
☐ Psychotherapy
□ Medication
☐ Outpatient Hospitalizations
☐ Inpatient Hospitalization
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If yes, please provide:
Name of provider or facility:
Location:
Location: Dates of treatment:
Dates of treatment:Reason for treatment:
neuson for d'ediffiche.
Briefly, what brings you in today
Briefly, What Brings you in coday
When did your problem first start? Within the last:
□ 30 days
□ 612 months
□ 2 years
□ During adolescence
☐ During childhood
What areas of your life have been affected because of this problem?
What areas of your life have been affected because of this problem?
Are you currently experiencing everyholming sedness, grief or depression?
Are you currently experiencing overwhelming sadness, grief or depression?
□ Yes
□ No
If yes, for approximately how long?
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Are you Y I	'es	ntly experiencing a	anxiety, panic attacks or have any ph	obias?
If yes, w	hen di	d you begin expe	riencing this?	-
Please o	lescrib	e any major losse	s or traumas you have experienced:	
What si	gnifica	nt life changes or	stressful events have you experience	ed recently?
What wo	ould yo	ou like to accompl	ish out of your time in therapy	
			Family History	
Where v	vere yo	ou born?		
	City Suburb Country	s /	ings. Please use additional space on t	the back if needed
Name	Age	Relationship	Where do they live now?	If deceased, age and cause of death
		-		-
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wno ala	you ii	ve with while grov	ving up?	
Mother's	s occup	oation:		
Father's	occup	ation?		

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

Condition	Please circle	List Family Member		
Alcohol/Substance Abuse	yes/no			
Anxiety	yes/no			
Depression	yes/no			
Domestic Violence	yes/no			
Sexual Abuse	yes/no			
Eating Disorders	yes/no			
Obesity	yes/no			
Obsessive Compulsive Disorder	yes/no			
Schizophrenia	yes/no			
Suicide Attempts	yes/no			
Other diagnosed mental health condition?	yes/no : which was			
 □ Married □ Separated □ Divorced For how long? □ Widowed: Please provide your partners name and year deceased: If married, how long have you been married for and what is your partners name:				
On a scale of 1-10 (best), how would you rat	_ e your relationship?			
Are you currently in a romantic relationship? ☐ Yes How long? ☐ No				
On a scale of 1-10 (best), how would you rate your relationship?				
Please list any children, their names, and ages:				

Name	Age	Relationship	Name of other parent	If deceased, age and cause of death

Physical Health

Please list any medications, herbs, or supplements. Be sure to include the condition, as some medications are prescribed for off-label use. Continue on the back if needed, or provide a separate list. If you have a complicated medical profile, please supply supporting documentation to be able to facilitate a comprehensive understanding of your health.

Medication/Supplement	Dosage	Condition	Date Began/Stopped
Prescribing provider and contact informat	ion:		
Name:			
Specialty:			
Facility:			
Phone, email, or Fax:			_
How would you rate your current physical Poor Unsatisfactory Satisfactory Good Very Good	health?		
Please list any specific health problems yo	ou are currently ex	periencing:	
How would you rate your current sleeping Poor Unsatisfactory Satisfactory Good Very Good If you are having problems, in which phas Falling asleep Staying asleep Awakening early Sleep apnea		experiencing issues?	

Please list any other specific sleep problems you are currently experiencing:

How many times per week do you generally exercise? What types of exercise do you participate in:
Are you currently experiencing any chronic pain? □ No □ Yes If yes, please describe:
Please describe current use of alcohol, cigarettes, and/or recreational drugs:
Please describe previous use of alcohol, cigarettes, and/or recreational drugs:
Additional Information
What do you enjoy about your work (full-time homemaker included)? If retired, what did you enjoy about your work?
What do you find particularly stressful about your current or previous work?
What do you enjoy doing in your free time? What do you do to relax?
Do you consider yourself to be spiritual or religious? If yes, please describe your faith or belief:
What do you consider to be some of your strengths?
What do you consider to be some of your weakness?