# Gina Campbell, LCSW, MDiv

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**FOR OFFICE USE ONLY**

*Client #*: _____
*Diagnosis*: _____
*Insurance:* _____
*EAP:* _____

*Need Monthly Statement?*
*Y N*

## CLIENT INTAKE FORM

Date: _____

*The information requested in this form will be kept confidential.*

**GENERAL INFORMATION:**

Last Name:_____ First Name: _____ Middle Initial: _____

Birth Date: ____/____/_____ Age: ___ Gender: □ Male □ Female □ Other Social Security #_____-____-_____

Address: _____
(Street and Number)

_____
(City) (State) (Zip)

Employer: _____ Profession/Vocation: _____

Religious Denomination/Spiritual preference: _____

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. To authorize email communication, please complete the "Consent to Correspond Electronically" Form.

Emergency Contact:_____ Telephone: _____

Relationship to you: _____

Marital Status: □ Single □ Domestic Partnership □ Married □ Separated □ Divorced □ Widowed

Please list any children/age: _____

_____

Referred by: _____

May we thank this person? □ Yes □ No

If so, please give contact information: _____

**INSURANCE INFORMATION** (if applicable):

Are you using insurance benefits? □ Y □ N

Are you: □ Primary Policyholder □ Dependent Relationship to Policyholder: _____

Insurance Company Name: _____

Street Address: _____ City: _____ State: ___ Zip:_____

Insurance ID #_____ Group #_____

Policy Holder's Name: _____ Policy Holder's Birth Date: _____/_____/_____

Policyholder's SSN #: _____-____-_____ Policyholder's Employer: _____

**GENERAL HEALTH AND MENTAL HEALTH INFORMATION:**

How would you rate your current physical health? (Please Circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:

_____

_____

_____

How would you rate your current sleeping habits? (Please Circle)

Poor Unsatisfactory Satisfactory Good Very good

How many times per week do you generally exercise? _____

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

_____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

□ No

□ Yes, previous therapist/practitioner: _____

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

Please list: _____

_____

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

Please list and provide dates: _____

_____

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

If yes, for approximately how long? _____

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

If yes, when did you begin experiencing this? _____

Do you drink alcohol more than once a week? □ No □ Yes If yes, how often? _____

Do you currently use tobacco products? □ No □ Yes

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

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? Bad 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 --- 10 Good

**PLEASE CHECK ALL THAT APPLY & CIRCLE THE MAIN PROBLEM:**

| Difficulty with: | now | past | Difficulty with: | now | past | Difficulty with: | now | past |
|---|---|---|---|---|---|---|---|---|
| Anxiety → | | | People in General → | | | Nausea → | | |
| Depression | | | Parents | | | Abdominal Distress | | |
| Mood Changes | | | Children | | | Fainting | | |
| Anger or Temper | | | Marriage/Partnership | | | Dizziness | | |
| Panic | | | Friend(s) | | | Diarrhea | | |
| Fears | | | Co-Worker(s) | | | Shortness of Breath | | |
| Irritability | | | Employer | | | Chest Pain | | |
| Concentration | | | Finances | | | Lump in the Throat | | |
| Headaches | | | Legal Problems | | | Sweating | | |
| Loss of Memory | | | Sexual Problems | | | Heart Palpitations | | |
| Excessive Worry | | | History of Child Abuse | | | Muscle Tension | | |
| Feeling Manic | | | History of Sexual Abuse | | | Pain in joints | | |
| Trusting Others | | | Domestic Violence | | | Allergies | | |
| Communicating with Others | | | Thoughts of Hurting Someone Else | | | Often Make Careless Mistakes | | |
| Drugs | | | Hurting Self | | | Fidget Frequently | | |
| Alcohol | | | Thoughts of Suicide | | | Speak Without Thinking | | |
| Caffeine | | | Sleeping Too Much | | | Waiting Your Turn | | |
| Frequent Vomiting | | | Sleeping Too Little | | | Completing Tasks | | |
| Eating Problems | | | Getting to Sleep | | | Paying Attention | | |
| Severe Weight Gain | | | Waking Too Early | | | Easily Distracted by Noises | | |
| Severe Weight Loss | | | Nightmares | | | Hyperactivity | | |
| Blackouts | | | Head Injury | | | Chills or Hot Flashes | | |

**FAMILY MENTAL HEALTH HISTORY:**

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

| History of: | | Yourself / Family Member Relationship: |
|---|---|---|
| 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 | |
| Sexual Abuse | yes / no | |
| Suicide Attempts | yes / no | |

**COUNSELING CONCERNS:**

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

_____
_____
_____
_____
_____

Please describe the concerns that bring you to counseling at this time:

_____
_____
_____
_____
_____

Please share what you hope to accomplish or gain through counseling:

_____
_____
_____
_____
_____