momentum
mental health

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Individual Client Intake Form

Please provide the following information for our records. Information you provide here is held to the same standards of confidentiality as our therapy. **Please print out this form and bring it completed to your first session OR allow yourself thirty minutes prior to your appointment to complete the form in the office.**

Name: _____ Date: _____
(Last) (First) (Middle Initial)

Spouse's Name (if married): _____
(Last) (First) (Middle Initial)

Local Address: _____
(Street and Number) (City) (State) (Zip)

Home Phone: ( ) _____ Cell/Other Phone: ( ) _____

Work Phone: ( ) _____ E-mail: _____

May we call and leave messages at home? □ Yes □ No On your cell? □ Yes □ No At work? □ Yes □ No
May we email you? □ Yes □ No

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

Marital Status: □ Never Married □ Partnered □ Married □ Separated □ Divorced □ Widowed

Number of Children: _____

Referred by: _____

Health and Social Information

How would you rate your current physical health? □ Excellent □ Good □ Fair □ Poor

Are you currently experiencing any physical problems (e.g. headaches, body aches, stomach problems)? Do you have chronic medical conditions or learning disabilities? If yes, please list: _____

_____

_____

Daily Medication(s)	Prescribing Physician

Family Physician: _____ Phone: _____

Have you been previously prescribed psychiatric medication?

□Yes □No If Yes, please list: _____

4. Are you having problems with your sleep habits? □ No □ Yes If yes, check all that apply:
□ Sleeping too little □ Sleeping too much □ Poor quality sleep □ Disturbing dreams □ Other _____

5. How many times per week do you exercise? _____ Approximately how long each time? _____

6. Have your appetite or eating habits changed? □ No □ Yes If yes, check all that apply:
□ Eating less □ Eating more □ Binging □ Restricting

7. How often do you use alcohol? □ Daily □ Weekly □ Monthly □ Rarely □ Never

8. Do you smoke? □ No □ Yes

9. How often do you engage in recreational drug use? □ Daily □ Weekly □ Monthly □ Rarely □ Never

If you engage in recreational drug use, what are your drug(s) of choice: _____

10. Are you currently or have you recently been in a romantic relationship? □ No □ Yes

If yes, how long have you been/were you in this relationship? _____

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

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

_____

Occupational Information:

Are you currently employed? □ No □ Yes

If yes, please list current employer and position? _____

If yes, are you happy at your current position? □ No □ Yes

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

Religions/Spiritual Information:

Do you consider yourself to be religious? □ No □ Yes

If yes, what is your faith? _____

If no, do you consider yourself to be spiritual? □ No □ Yes

Personal and Family Mental Health History

1. Have YOU ever experienced:

Extreme depressed mood: □ No □ Yes
Wild Mood Swings: □ No □ Yes
Extreme Anxiety: □ No □ Yes
Homicidal Thoughts: □ No □ Yes
Suicide Attempt: □ No □ Yes
Self Injurious Behavior: □ No □ Yes
Panic Attacks: □ No □ Yes
Phobias: □ No □ Yes
Sleep Disturbances: □ No □ Yes
Hallucinations: □ No □ Yes
Rapid Speech: □ No □ Yes
Unexplained losses of time: □ No □ Yes
Unexplained memory lapses: □ No □ Yes
Sexual Addictions: □ No □ Yes
Alcohol/Substance Abuse: □ No □ Yes
Memory Loss or Dementia: □ No □ Yes
Frequent Body Complaints: □ No □ Yes
Eating Disorder: □ No □ Yes
Body Image Problems: □ No □ Yes
Repetitive Thoughts (e.g., Obsessions) : □ No □ Yes
Repetitive Behaviors (e.g. Frequent Checking, Hand-Washing): □ No □ Yes

2. Have you had previous counseling, psychiatric services or psychotherapy? □No □Yes

If yes, previous therapist's name _____

3. Have you ever had suicidal thoughts in the past? □No □Yes Have you had any recently? □No □Yes

Do you have them today? □No □Yes Have you ever been hospitalized for suicidal thoughts? □No □Yes

4. Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (circle any that apply and list family member, e.g., Sibling, Parent, Uncle, etc.):

Difficulty	**Family Member(s)**
Depression: □ No □ Yes	_____
Bipolar Disorder: □ No □ Yes	_____
PTSD (Military or Other): □ 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	_____

5. Please indicate which of the following are currently problems for you:

□ Feeling inferior to others
□ Under too much pressure and feeling stressed
□ Excessive down or unhappy/depressed mood
□ Excessive anxiety or worry
□ Feeling lonely
□ Feeling paranoid
□ Crying spells
□ Obsessions/Compulsions
□ Concerns about finances
□ Feeling "numb" or cut off from others
□ Not being able to say what you really think or feel
□ Angry outbursts
□ Excessive fear of specific places or objects
□ Difficulty making/keeping friends
□ Eating too little/much, bingeing and purging
□ Feeling as if you'd be better off dead
□ Feeling out of control or manipulated by others
□ Difficulty making decisions
□ Loss of interest in sexual relationships
□ Other: _____

Reasons for Seeking Help

What concerns have brought you to counseling today? _____

_____

Where are these concerns causing the most problems for you?

□ Home □ School □ Social □ Other _____

When did these concerns begin to be a problem for you? _____

What concerns about you have been identified by others?_____

Other Information:

What do you like most about yourself? _____

_____

What are your goals for therapy? _____

Is there anything else you would like me to know today? _____

_____

How Did You Hear About Momentum Mental Health? _____