

Date: ____/____/____



SPARROW HOUSE
COUNSELING

Client Intake Information

Name: _____
Last First Middle/Maiden

Home Address: _____
Street City State Zip

Phone: _____/_____/_____
Home Work Cell

May I contact you via: Hm Phone: Yes ___ No ___ Wk Phone: Yes ___ No ___ Cell Phone: Yes ___ No ___

May I leave a message on: Hm Phone: Yes ___ No ___ Wk Phone: Yes ___ No ___ Cell Phone: Yes ___ No ___

Email Address: _____ Social Security #: _____ - _____ - _____

D.O.B. ____/____/____ Age: _____ Gender: _____ Place of Birth: _____

Marital Status: S M D W If married, how long? _____ Spouse's Name _____

Your Employer: _____ Position _____

Religion as a child: _____ Currently: _____

Referral Source: _____/_____
Name Address

If someone referred you to our office, I would like to thank him or her for the referral. May I have permission to send a thank you note? Yes _____ No _____

Person to contact in case of emergency: _____ Telephone: _____

PEOPLE CURRENTLY IN HOUSEHOLD INCLUDING YOURSELF

	Name	Relationship to Client	Age	Gender	Educational Level	Occupation
1	You	Self	X	X		
2						
3						

4						
5						
6						

Continue on back if necessary

Any children not living in household? _____

What is your major concern that led you to seek help?

What other concerns do you have?

Please describe any “yes” answers to the questions below.

Are you consistently down or depressed mood most of the day or nearly every day? ____ Yes ____ No

Do you have a diminished level of interest in most or all activities? ____ Yes ____ No _____

Change in appetite? ____ Yes ____ No _____

Change in weight? ____ Yes ____ No _____

Change in sleep pattern? ____ Yes ____ No _____

Fatigue or loss of energy? ____ Yes ____ No _____

Feelings of worthlessness or excessive guilt? ____ Yes ____ No _____

Difficulty thinking or concentrating? ____ Yes ____ No _____

Thoughts of death or suicide (or any attempts)? ____ Yes ____ No _____

Increased irritability or violent behavior? ____ Yes ____ No _____

Attacks of hyperventilation, palpitations or intense fear? ____ Yes ____ No _____

Any phobias or unusual fears? ____ Yes ____ No _____

Ever experience a “natural high” in absence of substance abuse (with increased energy, mood, decreased need for sleep, talkativeness, etc.)? ____ Yes ____ No _____

Height _____ Weight _____ Highest Weight _____ Lowest Weight _____

Any history of food binging? _____

Any use of laxatives, diuretics, diet pills, purging or food restriction? (Please circle and describe) _____

Any history of excessive alcohol and/or drug use? (Briefly describe) _____

Have you experienced any traumatic events as a child or adult? (Briefly describe) _____

Have you ever been in therapy? (Give name of therapist, dates and describe issues that were discussed)

Any major medical problems (i.e. thyroid, diabetes, asthma, etc.)? _____

Any prior hospitalizations (give date, reason, type of treatment)? _____

Are you currently under the care of a physician and/or psychiatrist? If so, whom? And for how long?

List all medications you are currently or have recently taken. Give names, dosage and duration of usage.

Research has shown that heredity plays a role in many disorders. Please take time to think of your various blood related relatives. Indicate any who have had similar symptoms as your self. Also, note if any had problems (even if no treatment was received) with the following: anxiety, depression, manic depression, changes in behavior or mood, eating disorders, phobias, suicidal behavior, drug or alcohol dependency, etc.) Please note any other emotional or medical problems.

RELATIVE

PROBLEM

Is there anything else that would be helpful for me to know about? _____

What do you hope or expect to gain from therapy? _____

I certify that this information is true and correct to the best of my knowledge. I will notify you of any changes regarding the above information.

SIGNATURE _____ DATE _____