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_____