Donna Alpner, LMFT

Intake Form

Date: _____

Client Information (***please print***)

Name: _____ Gender: ◯ M ◯ F

Address: _____

City: _____ State: _____ ZIP: _____

Home Phone: _____ Mobile: _____

Work Phone: _____ Date of Birth: _____

Email: _____

Social Security #: _____ Employer: _____

Client Relationship to Insured: _____ Marital Status: ◯ Single ◯ Married

◯ Divorced ◯ Separated

Allergies: _____

Medications: _____

Referral Source: _____

Reason for seeking counseling (Goal): _____

_____

_____

In Case of Emergency, notify

Name: _____ Tel #: _____ Relationship: _____

Insured's Information ****Copy of insurance card(s)****

Name: _____ Gender: ◯ M ◯ F

Address: _____

City: _____ State: _____ ZIP: _____

Phone #: _____ Date of Birth: _____

Email: _____

Social Security #: _____ Employer: _____

Insurance Information *(unnecessary with copy of insurance card—front and back)*

Insurance Carrier: _____

Member ID #: _____ Group #: _____ Auth # _____

City: _____ State: _____ ZIP: _____

Please provide the following information for my records. Leave blank any question you would rather not answer or would prefer to discuss. Information you provide here is held to the same standards of confidentiality as therapy.

Treatment History

Are you currently receiving psychiatric services, professional counseling or psychotherapy elsewhere? ◯ N ◯ Y

Have you had previous psychotherapy? ◯ N ◯ Y

Are you currently taking prescribed psychiatric medications (antidepressants, mood stabilizers, antianxiety, other)?

If yes, please list: _____

Prescribed by: _____

Health and Social Information

Do you currently have a primary physician? ◯ N ◯ Y

If yes, physician's name: _____

Are you currently seeing more than one medical health specialist? ◯ N ◯ Y

If yes, please list: _____

When was your last physical? _____

Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.) _____

_____

Are you currently on medication to manage a physical health concern?

If yes, please list: _____

Are you having any problem with sleep? ◯ N ◯ Y

If yes, check applicable:

◯ Sleeping too little ◯ Sleeping too much ◯ Poor quality sleep ◯ Disturbing dreams

◯ Other: _____

_____

How many times per week do you exercise? _____

Approximately how long each time? _____

Are you having difficulty with appetite or eating habits? ◯ N ◯ Y

If yes, check applicable:

◯ Eating less ◯ Eating more ◯ Bingeing ◯ Restricting

◯ Other: _____

Have you experienced significant weight change in the past 2 months? ◯ N ◯ Y

Do you regularly use alcohol? ◯ N ◯ Y

In a typical month, how often do you have 4 or more drinks in a 24 hour period? _____

How often do you engage in recreational drug use?

◯ Daily ◯ Weekly ◯ Monthly ◯ Rarely ◯ Never

Do you smoke cigarettes or use other tobacco products? ◯ N ◯ Y

Have you had any issues with domestic violence? ◯ N ◯ Y

If yes, please explain: _____

Have you had suicidal thoughts recently?

◯ Frequently ◯ Sometimes ◯ Rarely ◯ Never

Have you had them in the past?

◯ Frequently ◯ Sometimes ◯ Rarely ◯ Never

Are you currently in a romantic relationship? ◯ N ◯ Y

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

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

In the past year, have you experienced any significant life changes or stressors?

If yes, please explain: _____

_____

_____

Have you ever experienced any of the following?

Extreme depressed mood	◯ N ◯ Y
Dramatic mood swings	◯ N ◯ Y
Rapid speech	◯ N ◯ Y
Extreme anxiety	◯ N ◯ Y
Panic attacks	◯ N ◯ Y
Phobias	◯ N ◯ Y
Sleep disturbances	◯ N ◯ Y
Hallucinations	◯ N ◯ Y
Unexplained losses of time	◯ N ◯ Y
Unexplained memory lapses	◯ N ◯ Y
Alcohol/substance abuse	◯ N ◯ Y
Frequent body complaints	◯ N ◯ Y
Eating disorder	◯ N ◯ Y
Body image problems	◯ N ◯ Y
Repetitive thought (e.g. obsessions)	◯ N ◯ Y
Repetitive behaviors (e.g. frequent checking, hand washing)	◯ N ◯ Y
Homicidal thought	◯ N ◯ Y
Suicide attempts	◯ N ◯ Y If yes, when?

Occupational Information

Are you currently employed? ◯ N ◯ Y

If yes, who is your current employer? _____

If yes, are you happy with your current position? ◯ N ◯ Y

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

_____

_____

Family Mental Health History

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following?

Difficulty		Family member (e.g. sibling, parent, uncle, etc)
Depression	◯ N ◯ Y	
Bipolar disorder	◯ N ◯ Y	
Anxiety disorder	◯ N ◯ Y	
Panic attacks	◯ N ◯ Y	
Schizophrenia	◯ N ◯ Y	
Alcohol/substance abuse	◯ N ◯ Y	
Eating disorders	◯ N ◯ Y	
Learning disabilities	◯ N ◯ Y	
Trauma history	◯ N ◯ Y	
Suicide attempts	◯ N ◯ Y	
Chronic illness	◯ N ◯ Y	