DR. MARGO KUSHNER, LCSW-C, AAMFT, RSW-C

CLIENT INTAKE FORM

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

Please print out this form and bring it to your first session.

Name:____
(Last) (First) (Middle Initial)

Address:

____
(Street and Number)
____
(City) (State) (Zip)

Home Phone: ( ) **-** **Cell/Work Phone** ( ) **-**

I give permission to be called at: HOME: Yes/No CELL/WORK :Yes/No

Special Instructions:____.

I understand that if I have caller ID, the counselors name will be disclosed.
Please Initial________

Email: ____________________________ May I email you? Yes/No

Birth Date: ______ /______ /______ Age: ________

Gender: ☐ Male ☐ Female

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

Number of Children: ________ Ages:________________________________

Referred by:
____

Current reason for seeking therapy:_________________________________

____

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<u>*Only fill out the following section if client is a minor</u>

Name of parents/guardian

____
(Last) (First) (Middle)

____
(Last) (First) (Middle)

Parents are: (circle) Married Separated Divorced Never Married

In the event of parents' separation and/or divorce, the court has set the following custody stipulations:

Physical Custody: (circle) mother father full shared other

Legal Custody: (circle) mother father full shared other

____
Signature (Client's Parents/Guardian if under 18) Date

HEALTH AND SOCIAL INFORMATION

1. How is your physical health at present? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

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

____

____

3. Are you having any problems with your sleep habits? ☐ No ☐ Yes
If yes, check where applicable:

☐ Sleeping too little ☐ Sleeping too much ☐ Poor quality sleep

☐ Disturbing dreams ☐ Other ____________________________

4. How many times per week do you exercise? ________

5. Are you having any difficulty with appetite or eating habits? ☐ No ☐ Yes
If yes, check where applicable: ☐ Eating less ☐ Eating more ☐ Binging

Have you experienced significant weight change in the last 2 months?
☐ No ☐ Yes

6. Do you regularly use alcohol? ☐ No ☐ Yes
In a typical month, how often do you have 4 or more drinks in 24-hours?____

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

8. Have you had suicidal thoughts recently?
☐ Frequently ☐ Sometimes ☐ Rarely ☐ Never

Have you had them in the past?
☐ Frequently ☐ Sometimes ☐ Rarely ☐ Never

9. Are you currently in a romantic relationship? ☐ No ☐ Yes
If yes, how long have you been in this relationship? __________________

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

Do you currently feel safe in this relationship? Yes/No

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

____

____

Have you ever experienced:

Extreme depressed mood	yes/no
Wild Mood Swings	yes/no
Rapid Speech	yes/no
Extreme Anxiety	yes/no
Panic Attacks	yes/no

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Phobias	yes/no
Sleep Disturbances	yes/no
Hallucinations	yes/no
Unexplained losses of time	yes/no
Unexplained memory lapses	yes/no
Alcohol/Substance Abuse	yes/no
Frequent Body Complaints	yes/no
Eating Disorder	yes/no
Body Image Problems	yes/no
Repetitive Thoughts (e.g., Obsessions)	yes/no
Repetitive Behaviors (e.g., Frequent Checking, Hand-Washing)	yes/no
Homicidal Thoughts	yes/no
Suicide Attempt	yes/no

Are you currently receiving psychiatric services, professional counseling or psychotherapy elsewhere? ☐Yes ☐No

If so please list helping professional's names:

_________________________________ _________________________________

_________________________________ _________________________________

Are you currently taking prescribed psychiatric medication (antidepressants or others)?
☐Yes ☐ No
If yes, please list:

____

If no, have you been previously prescribed psychiatric medication? Please list:

____

OCCUPATIONAL INFORMATION

Are you currently employed? ☐ No ☐ Yes If yes, who is your current employer/position?

____

If yes, are you happy at your current position? _________________

Please list any work-related stressors, if any___________________

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RELIGIOUS/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

SEXUAL HEALTH HISTORY

Are any of your current concerns related to your sexuality? Yes/No

If yes, what are your concerns? _____________________________

Do you have any current/past experiences with sexual abuse or trauma? Yes/No

FAMILY MENTAL HEALTH HISTORY

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
Depression	yes/no	
Bipolar Disorder	yes/no	
Anxiety Disorders	yes/no	
Panic Attacks	yes/no	
Schizophrenia	yes/no	
Substance Abuse	yes/no	
Eating Disorders	yes/no	
Learning Disabilities	yes/no	
Trauma History	yes/no	
Suicide Attempts	yes/no	

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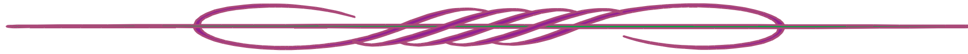

OTHER INFORMATION

What do you consider to be your strengths?

What do you like most about yourself?

What are effective coping strategies that you've learned?

What are your goals for therapy?

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