DC VA Counseling Psychotherapy, LLC

200 Little Falls S. 306, Falls Church, VA 22046
isabelbk08@gmail.com
703-231-7991

CLIENT INTAKE FORM

Please provide the following information for my records.
Leave blank any question you would rather not answer or does not apply to you.
Information you provide here is held to the same standards of confidentiality as our therapy.
Please fill out this form and bring it to your next 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
Is it ok to leave a message? Home: Yes/No Cell/Work: Yes/No

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

Email: _____ May I email you? Yes/No

Emergency Contact:_____ **Emergency Contact Phone**: _____

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:

_____

HEALTH AND SOCIAL INFORMATION

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

Poor Unsatisfactory Satisfactory Good Very good

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

_____

_____

2b. What medications are you currently taking? Please list them here.

_____

_____

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:
□ Starving myself □Eating less □ Eating more □ Binging □ Vomiting

Have you experienced significant weight change in the last 6 months?
□ No □ Yes

6. How often do you regularly use alcohol? □Never □ Rarely □ Daily
In a typical week, 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 or in the past? When?_____
□ 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 feel safe the relationship is affecting other aspects of your life? Yes/No

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

Have you ever experienced or are you currently experiencing:

□Unfulfilled relationships □Depressed mood

□Mood Swings □Irritability

□Rapid Speech □Anxiety/Anxious Thought

□Panic □Phobias

□Anger/Rage □Sleep Disturbances

□Hallucinations □Unexplained losses of time

□Unexplained memory lapses □Alcohol/Substance Abuse

□Frequent body complaints □Eating disorder

□Body image problems □Impulsive behavior

□Loss of concentration □Uncontrolled grief

□Homicidal Thoughts □Suicide Attempt

□Self-Injury/Cutting □Abuse

□Significant Traumatic Experience

□Repetitive thoughts (e.g., Obsessions)

□Repetitive behaviors (e.g., Frequent Checking, Hand-Washing)

Are you currently receiving or have you in the past received psychiatric services, professional counseling or psychotherapy elsewhere? □Yes □No

If yes, please list helping professional, time, and reasons:

_____

_____

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:

Have you ever been hospitalized? □ Yes □ No If yes, when and for what?

_____

OCCUPATIONAL INFORMATION

Are you currently employed? □ Yes □ No

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

On a scale of 1-10, how satisfied are you in your current position? _____

Please list any work-related stressors, if any_____

_____

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

On a scale of 1-10, how spiritual do you consider yourself? _____

SEXUAL HEALTH HISTORY

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

If yes, what are your concerns? _____

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 If yes, how many _____.

OTHER INFORMATION (Write in the back)

What do you consider to be your strengths and weaknesses?

What do you like most and least about yourself?

Do you have anybody you would say is a source of support for you?

Have you thought of your goals for therapy? If so please list them. If not, it is ok.