

ARIZONA BODY-MIND COUNSELING

OFFICE OF ART MATTHEWS, MA LPC

Client Intake sheet

Personal Information

Name _____

Address _____

City _____ State _____ ZIP _____ Date of Birth ____/____/____

Home Phone _____ Cell phone _____

Preferred e-mail address _____@_____._____

Any ways you **do not** want to be contacted email phone cell phone

Emergency Contact _____ Phone # _____

Relationship to you _____

Name of PCP or prescribing Physician: _____

Please briefly describe the reason you are seeking counseling: _____

How were you referred to counseling:

- Self Friend Other: _____
 Partner/Family Physician

Family Background

Spouse or Significant Other _____

Children (and ages) _____

Parents or Step Parents _____

Siblings _____

Any family issues that may be presently impacting your situation _____

Medical History

Client Name _____

Date of Birth ____/____/____

Please describe any counseling or psychiatric treatment you have received in the past:

Please describe any treatment you have received for substance abuse:

Please list any past or current physical health issues, surgeries, or injuries:

Please list any prescribed or over-the-counter medications you take, including any holistic herbs or medicines.

Are you now, or have you ever taken any medications for anxiety, depression, hallucinations, delusions, bipolar disorder or explosive disorder)? Yes No

Which of the following are you now experiencing? (Check all that apply)

- | | |
|---|--|
| <input type="checkbox"/> Feeling down, depressed or hopeless | <input type="checkbox"/> Difficulty concentrating |
| <input type="checkbox"/> Loss of interest/pleasure in things you once enjoyed | <input type="checkbox"/> Recurrent and persistent thoughts or images |
| <input type="checkbox"/> Thoughts of suicide or suicide attempts | <input type="checkbox"/> Inability to control or excessive control over what or how much you eat |
| <input type="checkbox"/> Noticeable sluggishness, fatigue or loss of energy | <input type="checkbox"/> Significant weight gain or loss |
| <input type="checkbox"/> Noticeable restlessness or fidgeting | <input type="checkbox"/> Use of alcohol/drugs to control mood |
| <input type="checkbox"/> Muscle tension, aches or soreness (not related to physical exertion) | <input type="checkbox"/> DUI |
| <input type="checkbox"/> Change in sleep habits | <input type="checkbox"/> Illegal drug use |
| <input type="checkbox"/> Trouble falling asleep or staying asleep | <input type="checkbox"/> Drinking alcohol against medical advice |
| <input type="checkbox"/> Marked change of appetite (either increased or decreased) | <input type="checkbox"/> Legal /work/school difficulties due to alcohol consumption/hangover |
| <input type="checkbox"/> Excessive worry or anxiety | <input type="checkbox"/> Dizziness or fainting spells |
| <input type="checkbox"/> Repetitive "checking" behaviors | <input type="checkbox"/> Head injury |
| <input type="checkbox"/> Panic attacks/Fear of leaving home | <input type="checkbox"/> Loss of or erratic menses |
| <input type="checkbox"/> Excessive energy or activity level | <input type="checkbox"/> Sexual difficulties |
| <input type="checkbox"/> Racing thoughts | <input type="checkbox"/> Learning difficulties or disabilities |
| <input type="checkbox"/> Frequent or severe headaches | <input type="checkbox"/> Experienced violence or assault |
| <input type="checkbox"/> Relationship problems | <input type="checkbox"/> Family history of mental health issues |
| <input type="checkbox"/> Becoming easily annoyed or irritable | <input type="checkbox"/> Family history of drug/alcohol abuse |
| <input type="checkbox"/> Verbal or physical aggression | <input type="checkbox"/> Violence within family and/or relationships |

Please describe: