joy full Living Center

Sarah Bowman Davila, LCSW

Client Intake Form

Today's Date: _____

Client Information

Full Name: _____ Date of Birth: _____ Age: _____

Address: _____
Street Address Apartment/Unit #

_____
City State Zip Code

Home Phone: _____ Cell Phone: _____ Text: (circle one) Yes ☐ No ☐

E-mail Address: _____
Please note: E-mail correspondence is not considered to be a confidential means of communication.

Best place to leave a message: **(please check one)** ☐ Home ☐ Cell ☐ Work ☐ E-mail

Emergency Contact: _____

Phone: _____ Relationship to you: _____

Current relationship status: **(please check one)**
☐ Single ☐ Married ☐ Widowed ☐ Divorced
☐ Long Term Relationship ☐ Other: _____

Who lives with you in your current household?
(First Name, Age, and Relationship to you)

_____

_____

Highest Grade/Degree: ☐ High School/GED ☐ College ☐ Graduate School ☐ Other: _____
School: _____ Major: _____

Are you currently employed? ☐ No ☐ Full-time ☐ Part-time

Occupation: _____ Employer: _____

Health Insurance Carrier: _____ Contract # _____

Subscriber: _____

Referred By: _____

FOR OFFICE USE ONLY:

☐ Genogram ☐ Social Atom ☐ Treatment Plan

☐ Coverage: _____ ☐ Diagnosis: _____

Medical Information – Physical

Medical Doctor: _____ Phone Number: _____

Address: _____

Date of last physical: _____

Date last seen: _____ Reason: _____

Are you currently being treated for any medical conditions? If so, what? _____

Past Care: Major medical problems, surgeries, accidents, falls, illness:

_____

_____

Please list any allergies: _____

Medications: Please list all the medications you are presently taking (prescription and over the counter):

Type/Name	Dosage	Purpose	Prescriber	Date Started	Benefits or Problems (list)

Past or Present Drug and Alcohol Use/Abuse

# of drinks per week: ☐ n/a ☐ 1-3 ☐ 4-6 ☐ 7-12 ☐ 13+ ☐ Other: _____

Has anyone complained about the amount you drink? ☐ Yes ☐ No ☐ If yes, who: _____

Age of first drink: _____

Do you smoke cigarettes? ☐ Yes ☐ No ☐ If yes, how many a day: _____

Other Substance Use: Type: _____ Frequency: _____ Date of Last Use: _____

_____ _____ _____

Legal

Have you ever been involved in any civil or criminal litigation, lawsuit or divorce or custody dispute, current, pending or past? (If the answer is yes, please explain):

_____

_____

Medical Information – Emotional

Please check off any of the following that you have experienced in the past or are presently experiencing:

	Present	Past		Present	Past
Anxiety	☐	☐	Increased Energy	☐	☐
Panic Attacks	☐	☐	Decreased Energy	☐	☐
Depressed Mood	☐	☐	Trauma	☐	☐
Loss of Interest or Motivation	☐	☐	Loss	☐	☐
Relationship Concerns	☐	☐	Inability to focus	☐	☐
Anger/ Irritability	☐	☐	Medical Concerns	☐	☐
Increased Appetite	☐	☐	Chronic Pain	☐	☐
Decreased Appetite	☐	☐	Self-harming behavior	☐	☐
Increased Alcohol / Drug consumption	☐	☐	Tearfulness	☐	☐
Racing Thoughts	☐	☐			
Delusions	☐	☐	Suicidal Thoughts	☐	☐
Hallucinations	☐	☐	Suicide Attempt(s)	☐	☐
Hopelessness	☐	☐	Violent Thoughts	☐	☐
☐ Lack of Memory: ☐ Long Term ☐ Short Term			Sexual Concerns	☐	☐
☐ Sleep: ☐ Trouble falling asleep; ☐ Trouble staying asleep			Phobia	☐	☐

Average # of hours of sleep a night ____

Prior Counseling Experience:

Name of Therapist Approximate Dates Reason

What are the presenting issues that brought you to therapy at this time?

What are your hopes for the therapy process at this time?

On a scale of 1 – 10 (1 being poor, 10 being great), how would you rate your:

___ Family Relationships
___ Romantic Relationship (s)
___ Friendships
___ Parenting Abilities (if applicable)
___ Self-esteem
___ Other: _____

___ Outlook on the Future
___ Job / School Satisfaction
___ Ability to Cope with Stress
___ Spirituality
___ Financial Management

Family Information

Family Medical and Psychiatric History: (Describe any physical or mental illness in your family)

Family History of Alcohol / Drug Problems: (Describe any abuse of substances in your family)

Have you experienced any of the following?

A violent or otherwise traumatic event? ☐ Yes ☐ No

Sexual abuse? ☐ Yes ☐ No

As an adult? ☐ Yes ☐ No As a child? ☐ Yes ☐ No

Physical or emotional abuse? ☐ Yes ☐ No

As an adult? ☐ Yes ☐ No As a child? ☐ Yes ☐ No

Social Information

Positive Recreational or Leisure Activities: (please list all that you participate in)

Spirituality / Religion:

Were you raised with any religious affiliations? ☐ Yes ☐ No ☐ If yes, what? _____

Do you attend services currently? ☐ Yes ☐ No ☐ If yes, where? _____

Are there any other activities you participate in for spiritual or personal growth? ☐ Yes ☐ No ☐ If yes, explain: _____