Ephphatha Counseling

Therapy Client Intake Form

CLIENT INFORMATION			
Full Name:			Relationship Status: ▫ S ▫ M ▫ D ▫ Sep ▫ W
Date of Birth:	Gender:		
Occupation:			
Employer/Company Name:			
Home Address w/zip code: Ok to mail to this address? ▫ Yes ▫ No	Email: Ok to email? ▫ Yes ▫ No (Please note that email correspondence is not guaranteed to be confidential)		
Home Phone#:	Cell Phone#:	Work Phone#:	
Ok to leave messages? • Yes ▫ No	Ok to leave messages? • Yes ▫ No	Ok to leave messages? • Yes ▫ No	
Have you previously attended therapy? ▫ Yes ▫ No What kind of therapy? Inpatient /Outpatient/ Other: _____	If yes, what was the length of treatment, and when were the dates attended? Length: Date(s):	If yes, why did you stop attending therapy?	

BIO-PSYCHO-SOCIAL HISTORY			
Symptoms and Behaviors (Please be as specific as possible to any 'yes' responses)			
Mania/manic symptoms	▫Yes	▫ No	If "Yes", circle severity: Low ←1 2 3 4 5 6 7 8 9 10 →High
Depressed Mood	▫Yes	▫ No	If "Yes", circle severity:

			Low ←1 2 3 4 5 6 7 8 9 10 →High
Appetite Disturbances	▫Yes	▫ No	If "Yes", circle severity: Low ←1 2 3 4 5 6 7 8 9 10 →High
Sleep Disturbances	▫Yes	▫ No	If "Yes", circle severity: Low ←1 2 3 4 5 6 7 8 9 10 →High
Change in Energy Level	▫Yes	▫ No	If "Yes", circle severity: Low ←1 2 3 4 5 6 7 8 9 10 →High
Decreased Concentration	▫Yes	▫ No	If "Yes", circle severity: Low ←1 2 3 4 5 6 7 8 9 10 →High
Worthless/Helpless Feelings	▫Yes	▫ No	If "Yes", circle severity: Low ←1 2 3 4 5 6 7 8 9 10 →High
Anxiety Symptoms/ Panic Attacks	▫Yes	▫ No	If "Yes", circle severity: Low ←1 2 3 4 5 6 7 8 9 10 →High
Bingeing/Purging	▫Yes	▫ No	If "Yes", circle severity: Low ←1 2 3 4 5 6 7 8 9 10 →High
Feelings of Guilt	▫Yes	▫ No	If "Yes", circle severity: Low ←1 2 3 4 5 6 7 8 9 10 →High
Obsessions/ Compulsions	▫Yes	▫ No	If "Yes", please describe:
Phobias	▫Yes	▫ No	If "Yes", please describe:
Medical Conditions	▫Yes	▫ No	If "Yes", please describe:
Hyperactivity	▫Yes	▫ No	If "Yes", please describe:
Are you having suicidal thoughts?	▫Yes	▫ No	If "Yes", do you have a plan on how you will commit suicide:
Do you have the means to carry out your plan?	▫Yes	▫ No	If "Yes", how would you do this?
Have you ever made a suicide attempt or been hospitalized for suicide?	▫Yes	▫ No	Describe: Date(s) of attempt(s):
Is there a history of suicide in your family of origin?	▫Yes	▫ No	If "Yes", please list who and what year:
Have you had a previous diagnosis by a therapist or psychiatrist?	▫Yes	▫ No	If yes, please list the diagnosis's and the years:

Prescription Medications (please list all currently taking or have taken, the length of time and what they are prescribed for: pain, illness, depression, etc.)

Please list your psychiatrist name and phone number:

Name: **Phone:**

1.
2.
3.
4.

List any other medications or comments that your therapist should be aware of regarding your physical or mental health:

Substance Use

Are you currently using alcohol, nicotine or other prescription or non-prescription drugs? Please list how much and how often you drink and/or take prescription or non-prescription drugs:	▫Yes	▫ No

Ethnic Group (circle all that apply):

Native/First Person Indian Black/African American Alaskan Native Caucasian
Middle Eastern Asian Filipino Native Hawaiian Pacific Islander Hispanic/Latin
Multi-Ethnic/Other_____

Thank you for taking time to read and complete these questions. This information will be helpful in your therapy process. Your signature is required before we can begin our work together;

- I have thoroughly read and fully understand the Informed Consent and therapy policies outlined in this document.
- I understand that I am financially responsible for charges and fees incurred. I agree to honor the 24 hour cancellation policy.

- I understand limits of confidentiality and all mandated reporting by my therapist.

- I agree to respect the boundaries of contact between sessions and understand email and text is not an appropriate form of processing what is best discussed in session.

- I understand that emailing, texting and cell phone are not guaranteed as confidential. I understand that there is the potential for human error by my therapist, or myself or an outside party may hack, or other risks can occur when communicating with my therapist via text, email, phone or other Internet platforms. I am aware of the risks, and accept responsibility for these risks should I choose to communicate via text, phone, email or Internet platforms.

- I have answered all questions in full, truthfully and to the best of my knowledge. I have had all questions about this document answered and sign willingly. I authorize my therapist to provide psychotherapeutic treatment for me, the client, signing below:

Client's name (printed): _____

Client's signature: _____ **Date:** _____

Therapist's signature: _____ **Date:** _____