Growing Bonds Counseling

Growing Bonds Counseling
5108 Broadway, Suite 226
San Antonio, TX 78209

Client Intake Form **Date:**_________________

Name:____ DOB: ____/____/______ Age:______

Residential Address:_____________________________________ City: ___________ Zip:______

OK to send treatment/billing information to this mailing address? Yes No

If no, please provide an alternative mailing address: ____

Home Phone: ____________________________ Messages OK? Yes No

Cell Phone: ______________________________ Messages OK? Yes No Carrier: ___________

Other Phone: _____________________________ Messages OK? Yes No

E-mail: __________________________________ Messages OK? Yes No

Emergency Contact: ________________________ Relationship to you: ______________________

Main Phone: ______________________________ Other Phone: ______________________________

Primary Care Physician: __________________________________ Phone: ______________________

Occupation: _______________________________ Employment Status: ________________________

Referred by: Insurance Company Physician Friend Other: ________________________

Relationship Status: Single Married Committed Relationship Divorced Separated Widowed

Names and Ages of any Children: ____

____

Intake Form **Client Name: ____**

Names, Ages, and Relationships of people living in the home: ___________________________________

____

Insurance Information

Name of Insured: ____ Date of Birth: _____________

Client's Relationship to Insured: Self Spouse Mother Father Child Guardian

Insurance Carrier: ______________________ Insurance Phone #: _______________ Co-pay $ ______

Member ID#: _____________________ Policy/Group #: ______________ SSN#: _________________

Employer: ____ Active Date: __________________

Intake Questionnaire

What brought you in to therapy today? ____

____

What do you wish to change or accomplish as a result of therapy? ________________________________

____

Have you been in therapy before? Yes No If yes, please state when and where: ________________

____

Was it a positive experience? Yes No What did you like/not like about it? ______________________

____

What are your strengths? ____

Intake Form **Client Name: ____**

Please circle all that apply and indicate for how long:	
Frequently sad or depressed	Feeling restless or keyed up
Overwhelming worries	Restless unsatisfying sleep
Difficulty falling or staying asleep	Muscle tension
Unable to concentrate	Panic Attacks
Irritable and/or short temper	Mood swings
Significant change in weight	Decreased need for sleep (only need 3-4 hours)
Low energy level/fatigue	Feel more talkative than usual
Feeling excessive guilt or shame	Excessive spending/shopping
Unable to relax	Excessive gambling
Lack of appetite/increased appetite	Easily distracted by unimportant things
Loss of interest in activities/hobbies	Take too many risks
Feeling hopeless	Substance abuse
Feeling worthless	Relationship problems
Difficulty motivating	Troubling thoughts about the past
Withdrawn/isolating self	Nightmares
Cry easily/often	Startle easily
Difficulty making a decision	Too neat and orderly
Difficulty finishing tasks	Repeating certain behaviors over and over
Difficulty with friends/family	Painful memories
Thoughts to hurt self	Easily upset or angered
Attempts to harm yourself	Feeling different from most people
Thoughts to hurt others	Shy around others
Threats to hurt others	Increasingly forgetful
Physical pain	Strong fears
Feeling ill/sick	Difficulty with work or school

Intake Form **Client Name: ____**

Medical History

Have you consulted a physician or psychiatrist regarding the problem that brings you here? Yes No

Are you currently being treated for any medical problems? Yes No

Are you currently taking any medications? Yes No

If yes, please indicate what medications: ____

Are you presently in good health? Yes No ____

Do you engage in physical activity? Yes No ____

Do you smoke cigarettes (cigars, chew)? Yes No # Per Day ___________

How much alcohol do you drink? # Per Day ____________ # Per Week _____________

Do you drink caffeinated beverages? Yes No If yes, how many per day? ____________

Do you use any other types of drugs? Yes No ____

Have you ever tried to cut down or stop using alcohol or drugs? Yes No

Has anyone ever asked you to cut down on your drinking/drugs? Yes No

Have you ever been hospitalized for any emotional/mental health condition? Yes No

If yes, please indicate for what and how long? ____

Intake Form **Client Name: ____**

Personal History

Have you experienced or witnessed a traumatic event? *(parental violence, domestic violence, community violence, natural disaster, injury or death to a loved one, etc.)* Yes No

Do you have a history of domestic violence? Yes No

Do you have a history of verbal, emotional or physical abuse? Yes No

Do you have a history of sexual abuse or sexual assault? Yes No

Are you or have you experienced legal problems? Yes No

If Yes on any of the above, please elaborate: ____

____

Support Systems		**Who or What?**
Do you have one or two friends that you consider close and feel you can depend on?	Yes No	
Do you have a religion or spiritual practice that you experience as supportive?	Yes No	
Do you belong to any social groups or participate in hobbies with people that you enjoy?	Yes No	
Is there a family member that you trust and can go to in times of emotional need?	Yes No	

Family History

Have you or anyone in your family experienced any of the following?

If yes, please note their relationship to you and include details if possible.

Please include extended family such as grandparents, uncles/aunts, siblings, and so on.

Have you or a family member experienced:	Indicate Self or which Family Member(s):
Anxiety	
Depression	
Bipolar Disorder	
Learning Disorders (ADHD, Dyslexia, etc.)	
Illicit Drug Use	
Alcohol Abuse	
Schizophrenia	
Anger	
Eating Disorder	
Phobias	
Hospitalization for Mental Health Condition	
Attempted or Completed Suicide	

Intake Form **Client Name: ____**

Please circle any of the following areas that you would like to address in therapy:

Feelings/Mood	Career/Education
Family	Phase of life
Children/Parenting	Stress
Relationships	Assertiveness
Alcohol or Drug use	Health problems
Verbal abuse	Childhood experiences
Physical abuse	Loss or death
Emotional abuse	Spirituality
Sexual abuse	Self esteem
Finances	Legal issues

Is there anything else that you would like me to know? ______________________________________

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