PRACTICAL THERAPEUTIC SOLUTIONS, PLLC

CLIENT INTAKE FORM: (please print)

Please provide the following information by answering the questions below. If the question does not apply to you, then put N/A. Please bring the filled out documents to your first session. If you are a couple, both parties please fill out separate documents. Please note that the information you provide here is protected as confidential information.

BASIC INFORMATION

Client Name:

_____

(First) (Middle Initial) (Last)

Client Address:

_____

(Number, Street, City, State, Zip Code)

Preferred Mailing Address: (unless same)

_____

(Number, Street, City, State, Zip Code)

Client Birth Date: ____/___/___ Client Age: ____ Gender: Male Female

Marital Status:
Never Married Domestic Partnership Married Separated Divorced Widowed
For how long?_____

Are you currently in a romantic relationship?
If yes, how would you describe it on a scale from 1 to 10 or in other words?

_____

Please list all children with names and ages:

_____

_____

_____

Home Phone:_____ May we leave a message? Yes No
Cell Phone: _____ May we leave a message? Yes No
Work Phone: _____ May we leave a message? Yes No

Preferred E-mail Address: _____
*Please note email correspondence is not considered to be confidential method of communication.

Referred by (if applies): _____

Why are you here today? What would you like to accomplish out of your time in therapy?

_____

_____

MENTAL HEALTH INFORMATION

1. Have you previously received any type of mental health services (psychotherapy, psychiatric, psychology services, etc.? Yes No
   If yes: Clinician Name, Address, & Contact Number

_____

_____

2. Are you currently taking any prescription medications? Yes No
   If yes: Doctor's Name, Address, Contact Number, & Types of Medication

_____

_____

3. Are you currently using or have been prescribed psychiatric medication? Yes No
   If yes: Doctor's Name, Address, Contact Number, Types of Medication, & Dates Prescribed

_____

_____

4. Have you **thought about or attempted harming** yourself or someone else? Yes No
   If yes: please list number of attempts, hospitalizations with dates, and method used.

_____

_____

. Do you own fire arms? Yes or No How many/access? _____

5. Are you currently experiencing overwhelming sadness, grief, or depression? Yes No
   If yes, for how long? Describe what you are feeling and thinking?

_____

_____

6. Are you currently experiencing anxiety, panic attacks, or have any phobias? Yes No
   If yes, for how long? Describe what and when you experienced this?

_____

_____

7 What significant life changes or stressful events have you experienced recently?

_____

FAMILY INFORMATION

	YES/NO	FAMILY MEMBER	KNOWN INFORMATION/SYMPTOMS
Alcohol Abuse			
Drug/Substance Abuse			
Domestic Violence			
Tobacco Usage			
Eating Disorders			
Obesity			
Obsessive Compulsive Behaviors			
Hoarding Behaviors			
Schizophrenia Diagnosis			
Bi-Polar Diagnosis			
Suicide Attempts			
Sexual Abuse			
Sexual Issues			
Emotional Abuse			
Work History			
Incarceration History			
Physical Abuse			

GENERAL HEALTH INFORMATION

Date of Last Physical: _____

1. How would you rate your current physical health?

   Poor Unsatisfactory Satisfactory Good Excellent

   Please list any specific health related problems you are currently experiencing plus allergy or alternative medical care information.

_____

_____

Primary Physician Name and Contact Number: _____

2. How would you rate your current sleeping habits? (please circle)

   Poor Unsatisfactory Satisfactory Good Excellent

   Please list any specific sleep related problems you are currently experiencing.

_____

_____

3. How many times a week do you exercise? Please name the exercise types you engage in.

_____

_____

4. Please list any difficulties you experience with your appetite or eating patterns.

_____

_____

5. Are you currently experiencing any chronic pain? Yes No
   How long? Please describe.

_____

_____

6. How often do you drink alcohol? _____
   At each setting, about how many alcoholic type drinks are consumed? _____
   Date of last alcoholic type drink? _____

7. How often do you engage in recreational drug usage?
   Daily Weekly Monthly Infrequently Never
   If so, what do you use and how often?
   _____

8. ? The state of Virginia may consider being involved with child pornography a mandated reportable incident.
   Do you view or are you involved in child pornography? Yes or No

ADDITIONAL INFORMATION

1. Is there anything else that I should know or you want to add?

_____

_____

I, _____ attest that all information that I have given in this Intake Form is truthful and accurate.

_____ _____ _____

Print Name Signature Date Completed