



Davis Dynamics

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CLIENT INTAKE FORM

Please provide the following information. Leave blank any question you don't want to answer. Information you provide here is confidential.

What brings you in? What goals would you like?

TREATMENT HISTORY

Are you currently receiving psychiatric services, professional counseling or psychotherapy elsewhere? yes no

If yes, whom and where? _____

Have you had psychotherapy in the past?

no

yes, with (previous therapist's name) _____

Did you find relief? no yes somewhat

What was the diagnosis? _____

Did you agree with the diagnosis? no yes somewhat

Are you currently taking prescribed psychiatric medication (antidepressants or others)? yes no

If yes, please list: _____

Prescribed by: _____

HEALTH AND SOCIAL INFORMATION

Do you currently have a primary physician? () yes () no

If yes, who is it? _____

Are you currently seeing more than one medical health specialist? () yes () no

If yes, please list: _____

When was your last physical? _____

Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.): _____

Are you currently on medication to manage a physical health concern? If yes, please list: _____

Are you having any problems with your sleep? () yes () no

If yes, check where applicable:

- () Sleeping too little () Sleeping too much () Poor quality sleep
- () Disturbing dreams () other _____

How many times per week do you exercise? _____

Approximately how long each time? _____

Are you having any difficulty with appetite or eating habits? () no () yes

If yes, check where applicable: () Eating less () Eating more () Bingeing
() Restricting

Have you experienced significant weight change in the last 2 months? () no () yes

Do you regularly use alcohol? () no () yes

In a typical month, how often do you have 4 or more drinks in a 24 hour period?

How often do you engage recreational drug use? () daily () weekly () monthly
() rarely () never

Do you smoke cigarettes or use other tobacco products? () yes () no

Have you had suicidal thoughts recently?
() frequently () sometimes () rarely () never

Have you had them in the past?
() frequently () sometimes () rarely () never

Have you ever attempted suicide? () no () yes
If yes, how many times? _____
If yes, how old were you? _____

Have you ever been admitted to inpatient psychiatric hospitalization? () no () yes
If yes, when and where? _____

Are you currently in a romantic relationship? () no () yes

If yes, how long have you been in this relationship? _____

On a scale of 1-10 (10 being the highest quality), how would you rate your current relationship? _____

In the last year, have you experienced any significant life changes or stressors? If yes, please explain: _____

Have you experienced any of the following within the past *six months*?

Extreme depressed mood	Yes / No
Dramatic mood swings	Yes / No
Rapid speech	Yes / No
Extreme anxiety	Yes / No
Panic attacks	Yes / No
Phobias	Yes / No
Sleep disturbances	Yes / No
Hallucinations	Yes / No
Unexplained losses of time	Yes / No
Unexplained memory lapses	Yes / No
Alcohol/substance abuse	Yes / No

Frequent body complaints	Yes / No
Eating disorder	Yes / No
Body image problems	Yes / No
Repetitive thoughts (e.g. obsessions)	Yes / No
Repetitive behaviors (e.g. frequent checking, hand washing)	Yes / No
Homicidal thoughts	Yes / No
Suicidal attempts	Yes / No If yes, when?

OCCUPATIONAL INFORMATION

Are you currently employed? () no () yes

Are you currently working full time at home as parent or caretaker? () no () yes

If employed, who is your currently employer/position? _____

If yes, are you happy with your current position? _____

Please list any work-related stressors, if any _____

RELIGIOUS/SPIRITUAL INFORMATION

Do you consider yourself to be religious? () no () yes

If yes, what is your faith? _____

If no, do you consider yourself to be spiritual? () no () yes

FAMILY MENTAL HEALTH HISTORY

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (circle any that apply and list family member, e.g. sibling parent, uncle, etc.)

Difficulty	Yes / No	Family member
Depression	Yes / No	
Bipolar disorder	Yes / No	
Anxiety disorder	Yes / No	
Panic attacks	Yes / No	

Schizophrenia	Yes / No	
Alcohol/substance abuse	Yes / No	
Eating disorders	Yes / No	
Learning disabilities	Yes / No	
Trauma history	Yes / No	
Suicide attempts	Yes / No	
Chronic illness	Yes / No	

In what area or areas do your symptoms negatively impact you? Please check all that apply:

- Duties at Work Children Family Self Care
 Relationship Coworkers Friends Duties at Home

Is there anything else you want me to know that hasn't been asked?

Whew! Congrats. You're finished with this part. Thank you! Please don't forget to bring this when we meet. - Jana

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