East Metro Family Counseling, LLC

Mitch Leppicello, LICSW

CLIENT INTAKE FORM

The following intake form is to be filled out by all new clients. The answers you provide will become part of your confidential mental health records. If you have any questions, feel free to discuss it with your intake therapist.

Today's Date: _____/_____/_____

Client Name _____ DOB: _____ Age:_____

Person Completing Form and relationship: _____

What is the main reason for coming to therapy today?

Have you had any previous mental health treatment/counseling: Yes No
If yes, please give details – when, where, How long, provider name, medications etc

Do you have any problems at *work* or difficulties in *school*? Yes No
If yes, please generalize history:

Are you currently (or in the recent past) taking any prescription or over the counter medications? : Yes No
If yes, please give details.

Does anyone else in your family (blood relatives) suffer from any mental or chemical health issues? Yes No
If yes, please give details:

Do you drink alcohol or use illegal drugs? Yes No
If yes, please give details – how much, how often, withdrawal signs, etc…

Have you ever suffered from any type of eating disorder (anorexia or bulimia)? Yes No
If yes, please give details:

Have you ever been charged with a crime, arrested or convicted? Yes No
If yes, please give details:

Do you or a family member have a history of trauma or violence *(victim or perpetrator)* Yes No
If yes, please give details:

PLEASE COMPLETE BACK SIDE

Symptom Checklist

	Not at all	Several days per wk	More than ½ the days	Nearly every day
Little interest or pleasure in doing things				
Feeling down, depressed, hopeless				
Trouble falling asleep, staying asleep, or sleeping too much				
Feeling tired or having little energy				
Low appetite or overeating				
Feeling bad about yourself, sense of failure, disappointment				
Trouble concentrating on things such as reading newspaper or watching t.v.				
Moving or speaking so slowly that other people could have noticed OR the opposite – fidgety, restless, moving around more than usual				
Thoughts that you would be better off dead, hurting yourself in some way, or hurting someone else				
SCORE:	0	1	2	3
Anxiety: obsessions, repetitions, worries, fears, phobias, panic feelings				
Impulsivity				
Inattention or distractibility				
Anger, irritability, or low frustration tolerance				
Oppositional, resistant to changes				
Problems with socialization, social skills, or social judgment				
Sensory integration problems: such as sounds, taste, touch, visual, smells				
Binging, purging, or use of diuretics				

How often do you have a drink containing alcohol?	never	Monthly or less	2-4 times per month	2-3 times per wk	4 or more times per week
How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 – 9	10 or more
How often do you have more than five or more drinks on one occasion?	never	< than monthly	Monthly	Weekly	Daily or almost daily
SCORE:	0	1	2	3	4

Any other comments or symptoms client is currently experiencing: _____

_____