



Balance Connection

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Intake Information

Please provide the following information and answer the questions below. Please fill out this form and bring it to your first session. Please note: Information you provide here is protected as confidential information.

GENERAL INFORMATION

Client's name: _____
(Last) (First) (Middle Initial)

Name of parent or legal guardian: (if under 18 years of age)

(Last) (First) (Middle Initial)

Client's Date of Birth: _____ Age: _____ Gender: (circle) Male Female

Marital Status: (circle) Never Married Domestic Partnership Married
Separated Divorced Widowed

Please list any children/age: _____

Please list any other family members living in the same household: _____

Please list other unrelated people living in the same household: _____

Client's Address: _____

City: _____ State: _____ Zip: _____

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

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

E-mail Address: _____ May we email you? Yes _____ No _____

(Please note: E-mail correspondence is not considered to be a confidential medium of communication)

Emergency Contact Name: _____ Relationship to Client: _____

Home Phone: _____ Cell Phone: _____

Referred by: (if any) _____

TREATMENTS & MEDICATIONS

Have you/your child previously received any type of mental health services (psychotherapy, psychiatric, etc.)?

Yes _____ No _____, Previous therapist/practitioner: _____

Are you/your child currently taking any prescription medications? Yes _____ No _____ If yes, please list:

Medication Name: _____ How long? _____

Medication Name: _____ How long? _____

Have you/your child ever been prescribed psychiatric medication? Yes _____ No _____

If yes, please list and provide dates:

Medication Name: _____ Dates: _____ to _____

Medication Name: _____ Dates: _____ to _____

HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate you/your child's current physical health? (circle)

Poor Unsatisfactory Satisfactory Good Very Good

Please list any specific health problems you/your child are currently experiencing:

2. How would you rate your/your child's current sleeping habits? (circle)

Poor Unsatisfactory Satisfactory Good Very Good

Please list any specific sleeping habit problems you/your child are currently experiencing:

3. How many times per week do you/your child generally exercise? _____

What types of exercise do you/your child participate in?

4. Please list any difficulties you experience with your/your child's appetite or eating patterns:

5. Are you/your child currently experiencing overwhelming sadness, grief or depression? Yes _____ No _____

If yes, approximately how long? _____

6. Are you/your child currently experiencing anxiety, panic attacks or have any phobias? Yes _____ No _____
 If yes, when did you/your child begin experiencing this? _____
7. Are you/your child currently experiencing any chronic pain? Yes _____ No _____
 If yes, please describe: _____
8. Have you/your child ever been a victim of physical abuse? Yes _____ No _____
9. Have you/your child ever been a victim of sexual abuse? Yes _____ No _____
10. Have you/your child ever experienced significant trauma? Yes _____ No _____

ADDITIONAL INFORMATION

1. Are you/your child currently employed? Yes _____ No _____
 If yes, what is your/your child's current employment situation? _____
 Do you/your child enjoy the employment? Yes _____ No _____
 Is there anything stressful about you/your child's current work? _____
2. Do you/your child consider yourself to be spiritual or religious? Yes _____ No _____
3. What do you consider to be some of your/your child's strengths? _____

4. What do you consider to be some of your/your child's weaknesses? _____

5. What would you like to accomplish during your/your child's time in therapy? _____

6. Do you/your child drink alcohol? Yes _____ No _____
 If so, is it more than once a week? Yes _____ No _____
7. How often do you/your child engage in recreational drug use? (circle)
 Daily Weekly Monthly Infrequently Never
8. Are you/your child currently in a romantic relationship? Yes _____ No _____
 On a scale of 1-10, how would you rate your/your child's relationship? _____
9. What significant life changes or stressful events have you/your child experienced recently? _____

10. Did you/your child achieve development tasks on target? Yes _____ No _____
 If no, please describe: _____

FAMILY MENTAL HEALTH HISTORY

In this section, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (ex. Father, Grandmother, Uncle, etc.)

Family Member

Alcohol/Substance Abuse Yes _____ No _____ _____

Anxiety Yes _____ No _____ _____

Depression Yes _____ No _____ _____

Domestic Violence Yes _____ No _____ _____

Eating Disorders Yes _____ No _____ _____

Obesity Yes _____ No _____ _____

Obsessive Compulsive Behavior Yes _____ No _____ _____

Schizophrenia Yes _____ No _____ _____

Suicide Attempts Yes _____ No _____ _____