Intake Registration

Thank you for your commitment to your mental health. This form helps me get some basic information, as well as give an opportunity for you(referred below as "Client") to share some of what you have been experiencing.

Client Information:		
First Name:	Last Name:	Date of Birth:
Employment (check all that apply): ☐ Unemployed/Retired ☐ Student at: ☐ Employed at: ☐ Other (specify):		
Phone:	Email:	
Preferred contact (choose as many as you like): ☐ Call ☐ Text* ☐ Email* ☐ Leave voicemail ☐ Postal mail **Text and Email are not considered secure platforms for protected health information. Further information is provided in the* ***Outpatient Mental Health Consent****.*		
Mailing address:	City:	Zip code:

Primary Care Physician:	Date last seen:
Previous/current medications:	
History of counseling (name of therapist & duration in treatment):	

What are your current concerns about your mental & behavioral health (check all that apply)?

☐ Often feel sad/down
☐ Often anxious/on edge
☐ Unable to focus
☐ Unable to sit still
☐ Difficulty making/keeping friends/relationships
☐ Physically aggressive (hitting, throwing things, etc.)
☐ Verbally aggressive (yelling, name-calling, etc.)
☐ Difficulty sleeping
☐ Other concerns:
☐ History of trauma
☐ Defying rules & expectations
☐ Strong mood swings
☐ Difficulty understanding/expressing emotions
☐ Uses alcohol/marijuana/other drugs 3+/week
☐ Requiring multiple reminders for tasks
☐ Thoughts/actions of self-harm
☐ Currently involved in the legal system (ie: custody battle, DUI...etc.)

Emergency Contact		
First name:	Last name:	Relation to client:
Phone:	Email:	
Preferred contact (choose as many as you like): ☐ Call ☐ Text* ☐ Email* ☐ Leave voicemail ☐ Postal mail **Text and Email are not considered secure platforms for protected health information.*		