Heather L. Rice, LMHC, PLLC

PO Box 3092, Oswego, NY 13126 PH: (315) 529-1008 FAX: (315) 295-2549 heatherricecounseling@gmail.com
www.heatherricecounseling.com

INTAKE

Please provide the following information and answer questions below. If you believe that a question does not pertain to you, you may leave it blank. Please note: information you provide here is protected as confidential information. Please fill out this form and bring it to your first session.

Client Name:_____
(Last) (First) (Middle Initial)

Name of parent/guardian (if under age 18):_____
(Last) (First) (Middle Initial)

Birth Date:____/____/____ Age:_____ Gender: ___ Male ___ Female _____ Transgender _____ Other

Local Address: _____ City/State: _____ Zip: _____
Home Address: _____ City/State: _____ Zip: _____
(Write SAME if home address is same as local)

Primary Phone: ( ) May we leave a message? ___ Yes ___ No

Secondary Phone: ( ) May we leave a message? ____ Yes ____ No

Email: _____ May we email you? ____ Yes ____ No
*Please note: Email correspondence is not considered a confidential medium of communication.

Referred by (if anyone): _____

Relationship Status: ___ Single ___ Serious dating or committed relationship
___ Domestic partnership ___ Married ___ Separated ___Divorced ___ Widowed

Immediate Relationships (Spouse, Children, Siblings, Parents, etc; use additional space as necessary):

Name	Relationship	Age	Location

What is the reason for seeking counselor at this time?

_____
_____
_____
_____

Have previously received any type of mental health services (counseling, psychiatric services, etc.)?

____ No

____ Yes: _____

Medication	Dates	Prescribing Doctor
Medication	Dates	Prescribing Doctor
Medication	Dates	Prescribing Doctor

Have you previously been hospitalized for a psychiatric reason (including substance abuse treatment)?

____ No

____ Yes, when: _____

Please indicate if and when you have had the following Experiences: (X)	NEVER	Within the past year	More than a year ago	Both
Purposely injured yourself without suicidal intent? (e.g. Cutting, hitting, burning, hair pulling, etc.)				
Seriously considered attempting suicide?				
Made a suicide attempt?				
Seriously considered injuring another person?				
Intentionally caused serious injury to another person?				
Had unwanted sexual contact(s) or experience(s)?				
Experienced harassing, controlling, and/or abusive Behavior from another person? (e.g., friend, family member, partner, authority figure, etc.)				
Legal issues?				

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. On a scale of 1-10 (with 10 being great) how would you rate your current physical health? _____
   Please list any specific health problems you are currently experiencing, including any disabilities:
   _____

2. On a scale of 1-10 (with 10 being great) how would you rate your current sleeping habits? _____
   How many hours of sleep per night do you average? _____
   Please list any specific sleep problems you are currently experiencing:
   _____

3. How many times per week do you generally exercise? _____
   What types of exercise do you participate in? _____

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

Have you ever suffered from an eating disorder? ___ No ____ Yes, please describe: _____

5. Are you currently experiencing sadness, grief, or depression? ___No ____Yes, for approximately how long?
_____

6. Are you currently experiencing anxiety, panic attacks or have any phobias? ____No ____ Yes, for approximately how long? _____

7. Are you currently experiencing chronic pain? ____ No ____ Yes, please describe:
_____

8. How often do you drink alcohol? ____ Daily ____Weekly ____Monthly ____Infrequently ____Never
Describe your alcohol use: _____

9. How often do you use recreational drugs (or other drugs not prescribed to you)? ____ Daily ____ Weekly
____Monthly ____Infrequently ____ Never
What drugs have you used in the past 30 days? _____

10. Do you smoke cigarettes? ____ No ____ Yes, for approximately how long and how much? _____

11. Are you currently in a romantic relationship? ____ No ____ Yes, for approximately how long? _____
On a scale of 1-10, how would you rate your relationship? ____

12. Describe any significant life changes or stressful events you have experienced lately:
_____
_____
_____
_____

13. Name of Primary Care Physician or Pediatrician: _____ Date of Last Visit: _____

FAMILY MENTAL HEALTH HISTORY:

In the section below, 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 (father, mother, grandmother, uncle, etc.).

	Please Circle	List 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	

ADDITIONAL INFORMATION:

1. Are you currently employed? ____ No _____ Yes
   If yes, describe your current employment situation: _____
   Do you enjoy your work? Is there anything stressful about your current work?
   _____
   _____

2. Do you consider yourself to be spiritual or religious? ____ No ____ Yes, describe your faith or belief:
   _____

3. Have you ever been enlisted in any branch of the U.S. Military? ___ No ____ Yes, which branch and what was your role?
   _____
   If yes, did your military experience include any traumatic or highly stressful experiences? ___ No ____ Yes

4. What is the most important thing that you would like to accomplish in therapy?
   _____
   _____
   _____
   _____
   _____

EMERGENCY CONTACT INFORMATION:

The following information will only be used in case of emergency.
Emergency contact person(s): _____
Relationship to you: _____
Phone number(s): _____
Address: _____