Jennifer L. Pfeffer, LCSW
814-923-8410

Client Intake Form (Adult)

Please provide the following information and answer the questions below. Please note that information you provide here is protected as confidential information.

Please fill out this form and bring it to your first session.

Date: ______________________________

Name: ____
(Last) (First) (Middle Initial)

Client Birth Date: ____ /____ /____ *Age:* _____ *Gender:* □ *Male* □ *Female*

Address: ____
(Street and Number)

____
(City) (State) (Zip)

Home Phone: ( )_______________________ *May we leave a message?* □ *Yes* □ *No*

Cell/Other Phone: ( )_______________________ *May we leave a message?* □ *Yes* □ *No*

E-mail: ____________________________________ *May we email you?* □ *Yes* □ *No*

Please note: Email correspondence is not considered to be a confidential medium of communication and will be utilized in rare cases only*

Marital Status:

□ *Never Married* □ *Domestic Partnership* □ *Married* □ *Separated* □ *Divorced* □ *Widowed*

Children (first name & ages)

____
____
____

Referred by (if any): ____

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

□ *No*
□ *Yes, previous therapist/practitioner:* ____

Why did you stop treatment?

____
____
____

Are you currently taking any prescription medication?
□ *Yes*
□ *No*
Please list:
____
____
____
____

Have you ever been prescribed psychiatric medication?
□ *Yes*
□ *No*
Please list and provide dates:
____
____
____
____

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, grandmother, uncle, etc.).

Please Circle and 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*	________________________
Bipolar Disorder	*yes/no*	________________________
Suicide Attempts	*yes/no*	________________________

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health? (please circle)

Poor *Unsatisfactory* *Satisfactory* *Good* *Very good*

Please list any specific health problems you are currently experiencing:
____
____
____
____

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2. How would you rate your current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:
____
____
____

3. Please list any difficulties you experience with your appetite or eating patterns:
____
____
____

4. Are you currently experiencing overwhelming sadness, grief, or depression?

□ No □ Yes

If yes, for approximately how long? ______________________________

5. Are you currently experiencing anxiety, panic attacks, or have any phobias?

□ No □ Yes

If yes, when did you begin experiencing this?
____
____
____

6. Are you currently experiencing any chronic pain?

□ No □ Yes

If yes, please describe:
____
____
____

7. Do you drink alcohol more than once a week? □ No □ Yes
Type ____________________ Frequency______________________

8. How often do you engage recreational drug use?

□ Daily □ Weekly □ Monthly □ Infrequently □ Never

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ADDITIONAL INFORMATION:

1. Are you currently employed? ☐ *No* ☐ *Yes*

If yes, what is 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*

If yes, please describe your faith or belief:

3. What do you consider to be some of your strengths?

4. What do you consider to be some of your weaknesses?

5. Why have you sought therapy treatment at this time?

6. What would you like to accomplish out of your time in therapy?