**Amanda Hartman, LCSW-R**

**Licensed Psychotherapist**

Cell (315) 882-1958

Fax (315)295-2526

Email: Amandashartman@gmail.com

Intake Form

Please provide the following information below. If you believe a question does not pertain to you, you may leave it blank. Information you provide is protected as confidential information.

Client Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Last) (First) (Middle Initial)

Parent/Guardian (if under 18):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Last) (First) (Middle Initial)

Date of Birth: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Age: \_\_\_\_\_ Gender: Male Female Transgender

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City/State:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip:\_\_\_\_\_\_\_

Primary Phone #: ( ) May I leave a message? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Secondary Phone#: ( ) May I leave a message? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship Status:

□Single □Married □Domestic Partner □Separated □Divorced □Widowed

Immediate Relationships (Spouse, Children, Siblings, Parents, etc.)

 Name Relationship Age Location

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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♦What is your reason for seeking counseling at this time? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

□No □Yes: if yes, please list the name of the Facilities/Therapists/Practitioners you worked with.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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♦Have you ever been prescribed psychiatric medication? □No □Yes: if yes, please list below.

Medication/Dose: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dates:\_\_\_\_\_\_\_\_\_\_\_\_ Prescriber: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medication/Dose: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dates:\_\_\_\_\_\_\_\_\_\_\_\_ Prescriber: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medication/Dose: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dates:\_\_\_\_\_\_\_\_\_\_\_\_ Prescriber: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medication/Dose: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dates:\_\_\_\_\_\_\_\_\_\_\_\_ Prescriber: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

♦Have you ever been hospitalized for psychiatric reasons (including substance abuse treatment)?

□No □Yes: if yes, please list where and when: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| Please note any recent changes in the following: |
|  |
| Sleep patterns: |  |
| Appetite: |  |
| Weight: |  |
| Energy level: |  |
| Pain level: |  |
| Depression level: |  |
| Anxiety Level: |  |

♦How often do you drink alcohol? □Daily □Weekly □Monthly □Infrequently □Never

♦How often do you use recreational drugs? □Daily □Weekly □Monthly □Infrequently □Never

 What drugs have you used in the past 30 days? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| **FAMILY MENTAL HEALTH HISTORY:** |
|  | Family Member (mom, dad, uncle, etc.) |
| Alcohol/Substance Abuse |  |
| Anxiety |  |
|  Depression |  |
| Schizophrenia |  |
| Obsessive Compulsive Behavior |  |
| Eating Disorder |  |
| Suicide Attempt |  |
| Other |  |

♦Please describe any significant life changes or stressful events you have recently experienced or are anticipating to experience. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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♦Are you currently employed? If yes, please describe? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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♦Name of Primary Care Physician or Pediatrician? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

♦General Health Concerns/Illness? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

♦Do you consider yourself to be spiritual or religious? If yes, please describe your faith or belief: \_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

♦Other information you believe is important for me to know and would like to share at this time. \_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**EMERGENCY CONTACT INFORMATION** (this information will only be used in case of emergency)

Emergency contact person:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to you:\_\_\_\_\_\_\_\_\_\_\_

Phone number(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_