Shirley Jones, LPC
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**CLIENT INFORMATION AND INTAKE**

**Name:** **Today's Date:**

**Name of parent/guardian (if under 18 years)**

**Gender:** **Age:** **Birthdate:**

**Address:** **SS#:**

**City:** **State:** **Zip:**

**Home phone:** **Work phone:**

**Mobile phone:** **Which phone is best to call?**

**Email:** **OK to leave phone messages?**

**Ok to Email?** ***Please note: Email correspondence is not considered to be a confidential medium of communication.**

**Background Information**

**Occupation:** **Employer:**

**Highest education:** **Time at current job:**

**Relational status:** **Length of current relationship:**

**Partner name:** **Children/dependents?**

**Ethnicity:** **Religious/Spiritual affiliation:**

**Sexual orientation:** **Other affiliations:**

**Emergency Contact:** **Relation to you:**

**Emergency phone:**

**Referred by (if any):**

**Insurance Information:**

*I am currently an in Network provider for United, Providence, Cigna, Aetna, BCBS, and Reliant. Depending on what coverage you may have I may be able to bill your insurance but as an out of network provider sometimes it means your insurance will cover less than an in network provider.*

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*Please ensure you look into your insurance information to understand what they will and won't cover with an out of network provider.*

*Would you like me to bill your insurance if possible? Yes or No (please circle one)*

**Insurance Company Name:**

**Policy Holder's Name:**

**DOB of Policy Holder:**

**Address of Policy Holder:**

**Place of Employment:**

**Member ID#:**

**Group #:**

**Relationship of client to Policy Holder:**

**Address where to send insurance claims:**

**What brings you in today?**

Describe what brings you in today?

When did these problems begin?

What areas of your life are being affected by this?

What are your strengths and ways of coping with stress?

What are your goals for therapy? What would successful change look like?

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**Mental Health History:**

**Have you had past mental health services?**

**Most recent Therapist?** **Phone:**

**What was most helpful and least helpful about past therapy?**

**Any history of abuse or domestic violence?**

**Any history of self-harm?**

**Any history of suicidal thoughts?**

**Any history of harming others or animals?**

**Any history of substance abuse?**

**Any history of substance treatment?**

**Any history of eating disorders?**

**Any information to share about family mental health history?**

**Are you currently taking any prescription medication if yes please list?**

**Have you ever been prescribed psychiatric medication if yes please list and the provide dates?**

**General Health:**

1. **On a scale of 1 through 10, 1 being poor, 10 being excellent, how would you rate your current physical health?**
    a. **Please list any specific health problems you are currently experiencing:**

2. **On a scale of 1 through 10, 1 being poor, 10 being excellent, how would you rate your current sleeping habits?**
    a. **Please list any specific sleep problems you are currently experiencing:**

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

4. **Please list any relationship difficulties you might currently be experiencing ex. Spouse, mom/daughter, father, partner, etc.?**

5. **What types of emotional stresses did you encounter growing up?**

6. **Where do you find social support currently? (i.e. people, social groups, etc.)**

**Family History:**

**Has any family member had a history of any of the below. Please respond yes or no, but if yes please indicate the family member's relationship to you (father, uncle, sister, etc.)**

- **Alcohol/Substance Abuse?**
- **Anxiety?**
- **Depression?**
- **Domestic Violence?**
- **Eating Disorders?**
- **Obesity?**
- **Obsessive Compulsive Behavior?**
- **Schizophrenia?**
- **Suicide Attempts?**

**Is there anything else you think might be important for me to know?**