Raduca Kaplan THERAPY

Client Intake

Please provide the following information and answer the questions below.
Please note:
information you provide here is protected as confidential information.
Please fill out this form and bring it to your first session.

Name: _____
(Last) (First) (Middle Initial)
Name of parent/guardian (if under 18 years):
_____
(Last) (First) (Middle Initial)
Birth Date: _____ /_____ /_____ Age: _____ Gender: _____
Marital Status:
☐ Never Married ☐Domestic Partnership ☐Married ☐Separated
☐ Divorced ☐ Widowed
Please list any children/age: _____
_____
_____
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.
Referred by (if any): _____
Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?
☐ No
☐ Yes, previous therapist/practitioner:_____
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: _____

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:

_____

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. How many times per week do you generally exercise? _____

What types of exercise to you participate in _____

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

_____

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

☐ No

☐ Yes

If yes, for approximately how long? _____

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

☐ No

☐ Yes

If yes, when did you begin experiencing this? _____

7. Are you currently experiencing any chronic pain?

☐ No

☐ Yes

If yes, please describe _____

8. Do you drink alcohol more than once a week? ☐ No ☐ Yes

9. How often do you engage recreational drug use?

☐ Daily ☐ Weekly ☐ Monthly ☐ Infrequently ☐ Never

10. Are you currently in a romantic relationship? ☐ No ☐ Yes

If yes, for how long? _____
On a scale of 1-10, how would you rate your relationship? _____
11. What significant life changes or stressful events have you experienced recently:_____

_____

_____

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 members relationship to you in the space provided (father, 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, 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, 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 weakness?

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