CLIENT PERSONAL INFORMATION

Psychotherapy Intake Form

LITTLE BIRD PSYCHOTHERAPY, P.S., INC

The information gathered in this form is used in conjunction with the clinical diagnostic interview.

Please provide the following information for intake purposes and LBP records. Leave blank any question you would rather not answer or would prefer to discuss in person. Information you provide here is held to the same standards of confidentiality as therapy. For adolescent clients 13 years old and older, please have the client, not the parent/ guardian, fill out and sign these documents.

Client Information

Client Name (legal):_____ Date of Birth:_____

Gender given at birth:_____ Gender Identity:_____ Sexual Orientation:_____

Client's Preferred Name & Pronouns:_____ Client's primary spoken language:_____

Client's Home Address:_____

Client's Phone Number: (Mobile)_____ (Home)_____

Client's E-mail Address: _____

Client's Employer (Company/Supervisor): _____

Work Address:_____ Work Phone Number:_____

Medical Insurance Information: (please provide insurance card)

_____

Primary Insurance Carrier Member ID Group Number Subscriber DOB

Emergency Contact Information:

Name:_____ Relationship to you:_____

Address:_____

Do you share an address with this contact? (circle one) Yes No Phone Number: (___)_____

Name:_____ Relationship to you:_____

Address:_____

Do you share an address with this contact? (circle one) Yes No Phone Number: (___)_____

CLIENT PERSONAL INFORMATION

Psychotherapy Intake Form

The following information helps me get a better picture of your situation, concerns and needs.

Background:

What prompted you to schedule an intake with Little Bird Psychotherapy?

_____

_____

_____

_____

_____

_____

Have you engaged in therapy/counseling before? (circle one) Yes No

***If yes, please fill out addendum form on the last page.**

Have you ever been prescribed psychiatric medication (e.g. an antidepressant)? (circle one) Yes No

If yes, please describe when and for what purpose psychiatric medications were prescribed as well as dosages, if known. Include and indicate any psychiatric medications being taken currently:

_____

_____

_____

_____

_____

_____

Have you ever attempted suicide? (circle one) Yes No

Have you ever been psychiatrically hospitalized? Yes No

Do you have a current or existing crisis plan with an outpatient provider? Yes No

**If yes, please provide LBP with a copy of this paperwork.*

Have you ever had an experience with PTSD or been diagnosed with PTSD? Yes No

Have you ever been sexually abused or witnessed sexual abuse? Yes No

Have you ever been physically abused or witnessed physical abuse? Yes No

Have you ever been emotionally abused or witnessed emotional abuse? Yes No

Have you ever been neglected or witnessed neglect? Yes No

Do you have any present or past difficulties with impulsive behaviors (check all that apply):

___Shoplifting/Stealing ___Problem/Pathological Gambling ___Compulsive sexual behavior

___Compulsive shopping ___Other:_____

CLIENT PERSONAL INFORMATION

Psychotherapy Intake Form

Substance Use/Treatment:

Do you drink alcoholic beverages?
___Never ___Rarely ___Occasionally ___Monthly ___Weekly ___Daily

Do you currently use cannabis? ___No ___Yes Method of Use: _____
___Per day: _____ times ___In a week: _____ times ___In a month: _____ times

Do you currently use street drugs or use any prescription drugs not as prescribed? ___No ___Yes
___Per day: _____ times ___In a week: _____ times ___In a month: _____ times

Do you smoke cigarettes or use tobacco products? ___No ___Yes
___Per day: _____ times ___In a week: _____ times ___In a month: _____ times

Do you ingest caffeine? ____No ___Yes
___Per day: _____ times ___In a week: _____ times ___In a month: _____ times

Have you ever felt guilt or remorse or has anyone else has been concerned about your drinking or drug use? Describe what help you sought or are seeking:

_____
_____
_____

Physical Health:

Any current or ongoing medical concerns:

_____
_____
_____

Who is your primary health care provider (i.e. physician, nurse, OB/GYN)?_____
When was your last physical?_____

Have you ever been hospitalized? (circle one) Yes No
Have you ever had surgery? (circle one) Yes No
Are you currently pregnant? (circle one) Yes No
If yes, has there been any prenatal exposure to drugs or alcohol? Yes No

Please list any non-psychiatric prescription medications, over-the-counter drugs, vitamins and/or herbal supplements that you currently take and dosages, if known:

_____
_____

Any allergies to food, drugs, or environmental sensitivities (i.e.- sensitivity to fragrance):

_____

CLIENT PERSONAL INFORMATION

Psychotherapy Intake Form

History:

Where were you born _____

Where were you raised _____

Who were your primary caregivers as a child (i.e. who raised you)? _____

_____

Describe your relationship with your parents/caretakers: _____

_____

How many children are in your family of origin?_____ Where are you in birth order (first, middle, etc.)?_____

Please indicate the presence of the following conditions in your history or your family's history:

Condition	You	Biological Mother	Biological Father	Biological sibling	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Other Relation
Depression									
Anxiety									
Eating Disorder									
Bipolar Disorder									
Drug/Alcohol Problems									
Obsessive Compulsive									
Psychiatric Hospitalization									
Schizophrenia									
Suicide or Attempt									
Alzheimer's or Dementia									
Asthma									
Cancer									
Developmental Disability									
Diabetes									
Epilepsy									
Heart Disease									
High Cholesterol									
High Blood Pressure									
Stroke									
Other									

CLIENT PERSONAL INFORMATION

Psychotherapy Intake Form

Current Life Situation:

Present Relationship Status: ___single ___engaged ___committed relationship ___married
___ separated ___divorced ___domestic partnership ___widowed

With whom do you live?

NAME	AGE	RELATIONSHIP TO YOU (e.g. mother, friend, etc.)

Housing Status: ___ House/Rent ___ House/Own ___ Apartment/Rent
___ Apartment/Own ___ Homeless ___ Other:_____

Do you believe that your basic needs are being met (i.e. clothing, shelter, etc.)? (circle one) Yes No
If no, please explain:

_____

_____

Do you feel safe in your home? (circle one) Yes No
Do you feel you have a sufficient social support system? Yes No
Do you confide in them about your problems? Yes No
Were your developmental milestones delayed or missed (i.e. walking, toilet training, talking, etc.)? Yes No
If yes, please explain: _____
What is your highest level of education? ___ High School Diploma ___ Some College
___ Associate's Degree___ Bachelor's Degree ___ Graduate Degree ___ Doctorate ___ Other:_____
Do you have any current literacy / reading issues? _____
Do you need the use of assistive technology? __Yes __No If yes, please explain: _____
What is your current employment status? ___ Employed ___ Unemployed ___ Retired
If employed, what is your current occupation?_____
How satisfied are you with your current job?_____
Have you ever received or do you currently receive financial assistance? Yes No
If so, please describe: _____
Do you have current or past military experience? Yes No
If so, please describe: _____
Legal History: __Criminal __Order of Protection/Restraining Order __Commitment __Guardianship __Other
If yes to any of the above, please describe:

_____

_____

CLIENT PERSONAL INFORMATION

Psychotherapy Intake Form

Please indicate if you are currently involved with and/or have the following:

- Powers of attorney: Yes* No
- Are you under civil or criminal court ordered mental health treatment: Yes* No
- Letters of guardianship / parenting plans / court order for custody: Yes* No
- Supervision by the department of corrections: Yes* No

**If answered yes to any of the questions above, please provide LBP with all relevant legal documents/paperwork*

Do you consider yourself to be spiritual or religious? Please describe any religious affiliation or spiritual beliefs and their impact, if any, on your service preferences:

_____

_____

Please indicate your ethnicity / cultural / tribal affiliation identification:

_____

What areas are stressful in your life? (i.e. finances, career, relationship, health, school, etc.):

_____

_____

Please describe attributes or characteristics that you view as personal strengths:

_____

_____

_____

Hobbies / Abilities / Interests:

_____

_____

_____

_____

Is there anything else you feel it is important for me to know right now?

_____

_____

_____

Notes for any questions or comments for LBP therapist:

_____

_____

_____

CLIENT PERSONAL INFORMATION

Psychotherapy Intake Form

Past Mental Health and Treatment History: Please include all treatment and services received within the last 5 years and any highly significant treatment received within the history of your life.

Approximate Start/End Dates	**Type of Treatment** (individual therapy, inpatient, residential, intensive outpatient, family, etc.)	**Name of Provider and Clinic/Facility**	**Address and Phone Number**	**For Provider Use Only**
Start: End:		Provider: Clinic/Facility:	Address: Phone / Fax:	___ROI on file, request sent to provider Date sent:_____ ___Client declined to release information
Start: End:			Address: Phone / Fax:	___ROI on file, request sent to provider Date sent:_____ ___Client declined to release information
Start: End:		Provider: Clinic/Facility:	Address: Phone / Fax:	___ROI on file, request sent to provider Date sent:_____ ___Client declined to release information
Start: End:		Provider: Clinic/Facility:	Address: Phone / Fax:	___ROI on file, request sent to provider Date sent:_____ ___Client declined to release information

SIGNATURES

My signature below indicates that I have been provided with a copy of this document, I have read and understand it, I was able to ask questions about its contents, and I consent to treatment by Little Bird Psychotherapy. My signature also indicates that I have been provided with a copy of the Notice of Privacy Practices and Statement of Client Rights and Responsibilities.

Client Signature:_____ Date:_____

Client Name (printed):_____ Date of Birth:_____

Parent/Guardian Signature*:_____ Date:_____

Parent/Guardian Name (printed)*:_____

**Required if client is a minor and under the state-mandated age of consent. Age of consent is 13 years old in the state of Washington, clients 12 years old and younger must have Parent/Guardian consent.*