GABRIELA PORTAS, ATR-BC, LCAT
PSYCHOTHERAPIST & CREATIVE ARTS THERAPIST
LICENSE NO. 001343-1

CLIENT INTAKE FORM

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

Today's Date: _____
(mm/dd/yyyy)

Client Name: _____ Date of Birth: _____
(First, Middle Initial, Last) (mm/dd/yyyy)

Name of parent/guardian (if client under 18 years): _____
(First, Middle Initial, Last)

Address: _____
(Street/P.O. Box) (Apartment/Suite)

_____
(City) (State) (Zip Code)

Phone #: _____ Alternate phone #: _____
Okay to leave message? ____Yes ____No Okay to leave message? ____Yes ____No

E-mail address: _____
Okay to communicate via email? ____Yes ____No
**Please note: Email correspondence is not considered to be a confidential medium of communication.*

Emergency contact: _____ Relationship to Client: _____
& contact's phone number: _____

Family Doctor: _____ Phone: _____

Referred by (if any): _____

Gender:

____ Female

____ Male

____ Transgendered [Check one: ____MTF ____FTM]

____ Other: _____

Race: _____

Ethnicity: _____

Religion/Spirituality: _____

Current Relationship Status:

____ Never Married

____ Married

____ Separated

____ Widowed:

____ Domestic Partnership

____ Involved with multiple partners

____ Divorced

____ Other: _____

If in a relationship: On a scale of 1-10, how would you rate your relationship? _____

Children (age/gender): _____

Living in the home: □ No □ Yes

Do you feel safe at home? _____Yes _____No _____Sometimes _____Prefer not to say

Education Level (highest grade completed): _____

Are you currently a student? _____No _____Yes; List educational program:_____

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?

_____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?
□ No
□ Yes

Are you currently receiving another type of mental health services (psychiatric services, individual/couples counseling, etc.)?
□ No
□ Yes; Name of current practitioner/Type of service: _____

Are you currently taking any prescription medication?
□ No
□ Yes; Please list: _____

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

HEALTH INSURANCE
Do you have Health Insurance? _____Yes _____No

If Yes, Insurance Carrier/Type: _____

If your health insurance is accepted as in-network at this Practice, I will ask you to complete a separate form regarding insurance information.

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 do 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. *How often do you drink alcohol?*
□ Never □ Infrequently □ Monthly □2-3x/Month □ Weekly □ Daily

9. *How often do you engage in recreational drug use?*
□ Never □ Infrequently □ Monthly □2-3x/Month □ Weekly □ Daily

10. *What significant life changes or stressful events have you experienced recently (put N/A if it applies):*
_____
_____

11. *In your own words, what is the nature of the concern that you wish to address in therapy?*
_____
_____
_____

Thank You for completing this Intake form.