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 here 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.*

Referred by (if any): _____

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

Name of Primary Care Physician: _____ Phone Number: _____

How many people reside in your household? _____

Any concerns about your current housing situation? _____ Yes _____ No

If yes, please specify: _____

Gender:

____ Female

____ Male

____ Transgendered [Check one: ____MTF ____FTM]

____ Other: _____

Race: _____

Ethnicity: _____

Religion/Spirituality: _____

Preferred Pronoun: _____
(she/he/they/etc.)

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

Current Relationship Status:

_____	Never Married	_____	Domestic Partnership
_____	Married	_____	Involved with multiple partners
_____	Separated	_____	Divorced
_____	Widowed:	_____	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: _____

<u>HEALTH INSURANCE</u>
Do you have Health Insurance? _____Yes _____No

If Yes, Insurance Carrier/Type: _____

Policy Number: _____ Group Number: _____

Annual Family Income: _____

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

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 feeling like/thinking about killing/hurting yourself?*
□ No
□ Yes
If yes: For approximately how long? _____
How frequently do you have these thoughts? _____
How long do they last? _____-

7. *Have you ever attempted to kill or hurt yourself?*

□ No
□ Yes

If yes, please describe when: _____

8. *Are you currently experiencing anxiety, panic attacks, or have any phobias?*
□ No
□ Yes
If yes, when did you begin experiencing this? _____

9. *Are you currently experiencing any chronic pain?*
□ No
□ Yes
If yes, please describe: _____

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

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

12. Do you have any disabilities?

□ No
▫ Yes

If yes, please describe: _____

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

13. *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.