

**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: _____
(First, Middle Initial, Last)

Date of Birth: _____
(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:

- | | |
|--|--|
| <input type="checkbox"/> Never Married | <input type="checkbox"/> Domestic Partnership |
| <input type="checkbox"/> Married | <input type="checkbox"/> Involved with multiple partners |
| <input type="checkbox"/> Separated | <input type="checkbox"/> Divorced |
| <input type="checkbox"/> Widowed: | <input type="checkbox"/> 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: _____

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: _____

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

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.