Intake Form

Client Information

Name ____ Date of Birth____________________

Address ____

____

Phone ______________________________ Email _______________________________________

Gender/Sex __________________________ Sexual Orientation ___________________________

Emergency Contacts

Name ________________________________ Name ________________________________

Relationship ___________________________ Relationship ___________________________

Phone ________________________________ Phone ________________________________

ONE BREATH COUNSELING
TRISHA CUPERO, LCSW

Mental Health

What brings you into therapy? ____

____

____

Do you have any mental health diagnoses? ____

Have you previously sought out mental health assistance? ________________________________

If so, who and where? ____

____

Are you on any psychiatric medications? If yes, what medications, dosage, and frequency?

____

____

Symptoms (circle all that apply)

Sad/depressed mood
Difficulty sleeping
Fear of social situations
Feelings of anxiety
Feeling on edge
Insomnia or hard to sleep
Panic attacks
Fun activities no longer fun
Trembling/shakiness
Restlessness
Feelings of guilt
Irritability
Low self esteem
Shortness of breath
Feelings of helplessness
Heart palpitations/chest pain
Feelings of hopelessness
Sweats
Fatigued/low energy
Dizziness
Decreased concentration

Nausea/abdominal distress
Indecisiveness/slowed thinking
Headaches
Rapid weight change
Feeling dissociated
Weight up/down
Menstrual problems/changes
Crying spells
Suicidal thoughts
Sexual problems
Self-harm/cutting
Unexplained pain
Tendency to isolate
Fear of being alone
Difficulty focusing
Difficulty with relationships
Difficulty in organizing tasks
Forgetfulness
Problems at work/home
Distractibility
Purging food

Impulsive
Dramatic mood swings
Amnesia
Increased energy
Feelings of numbness
Feeling elated
Nightmares
Racing thoughts
Overspending
Bizarre experiences
Unsafe sexual activities
Hallucinations
Decreased need for sleep
Intrusive bothersome thoughts
Repetitive compulsions
Alcohol abuse/dependency
Drug abuse/dependency
Difficulty with control of anger
Homicidal or violent thoughts
Family problems
Legal problems

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General Health

How is your physical health? ____

Are you diagnosed with any medical conditions I should be aware of? _________________

____

Are you taking any medications for health? _______ If so, what? ____________________

____

Any over-the-counter medications? ____

How often do you exercise? ____

How is your appetite? ____

Substance or Drug Use? ________ If so, what and how often? ______________________

Do you drink alcohol? _________ If so, how often? ____________________________

Do you use nicotine? __________ If so, how much? __________________________

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Family History

How would you describe your relationship with your family? ______________________________

____

____

Please indicate any of the following:

	Yes	No	Family members
Anxiety			
Depression/Bipolar			
Eating Disorders			
Schizophrenia			
Alcoholism			
Drug Abuse			
Suicide/suicide attempts			
Incarceration			
Domestic Violence			
Deceased			
Other: ________________			

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Home Life

Who do you live at home with? ____

Do you feel safe at home? ____

Are you in a relationship? _________ If so, tell me about your relationship and/or history.

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____

____

Employment/School Status

Are you currently working? ______ If so, where? ______________________________________

What is your occupation? ____

Are you currently in school? ______ If so, where? ______________________________________

What are you studying? ____

What is your highest level of education? ____

Tell me about your work/school. Any problems or concerns? ______________________________

____

Who are your supports? ____

____

How do you normally cope with your problems? ____

____

Do you have a religious or spiritual practice? ____

____

Anything else you'd like me to know? ____

____

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Appointment Availability (check all availability)

	Monday	Tuesday	Wednesday	Thursday	Friday
9am-10am					
10am-11am					
11am-12pm					
12pm-1pm					
1pm-2pm					
2pm-3pm					
3pm-4pm					

TRISHA CUPERO, LCSW

How did you hear about me? ____

____ ________________

Signature Date

____

Print Name

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