Remedy Road LLC

CLIENT INTAKE FORM

Section	Fields
CLIENT INFO	DOB .... Place of Birth .... SSN .... Medicaid Number ....
SERVICE COORDINATOR	Phone .... Email ....
GUARDIAN	Phone .... Email ....
PCP DOCTOR	Name .... Phone .... Address ....
DENTAL	Name .... Phone .... Address ....
THERAPIST	Name .... Phone .... Address ....
PSYCHIATRIC DOCTOR	Name .... Phone .... Address ....
VISION	Name .... Phone .... Address ....
LAST FBA	Date ....
LAST MENTAL HEALTH EVALUATION	Date ....

Are you currently taking prescribed psychiatric medication (antidepressants or others)?

☐ Yes ☐ No

If yes, please list: ______________________________

Prescribed by: ______________________________

HEALTH AND SOCIAL INFORMATION

Do you currently have a primary physician?

☐ No ☐ Yes, If yes, who is it? ______________________________

Are you currently seeing more than one medical health specialist?

☐ No ☐ Yes, If yes, please list: ______________________________

When was your last physical? ______________________________

Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.: ______________________________

____

Are you currently on medication to manage a physical health concern? If yes, please list:

1 ....
2 ....
3 ....
4 ....
5 ....
6 ....

Are you having any problems with your sleep habits?

☐ No ☐ Yes, If yes, check where applicable:

☐ Sleeping too little ☐ Sleeping too much ☐ Poor quality sleep

☐ Disturbing dreams ☐ other ______________________________

How many times per week do you exercise? ______________________________

Approximately how long each time? ______________________________

Are you having any difficulty with appetite or eating habits?

☐ No ☐ Yes, If yes, check where applicable:

☐ Eating less ☐ Eating more ☐ Bingeing ☐ Restricting

Have you experienced significant weight change in the last 2 months?

☐ No ☐ Yes

APPOINTMENTS

Doctor visits in the last 30 days:

1 ....

2 ....

3 ....

4 ....

5 ....

6 ....

7 ....

8 ....

UPCOMING APPOINTMENTS

1 ....

2 ....

3 ....

4 ....

5 ....

WHAT ARE YOUR LONG-TERM GOALS MEANING WITHIN 1 YEAR?

1 ....

2 ....

3 ....

4 ....

5 ....

WHAT ARE YOUR SHORT-TERM GOALS MEANING IN 4 TO 6 MONTHS?

1 ....

2 ....

3 ....

4 ....

5 ....

TREATMENT HISTORY

Are you currently receiving psychiatric services, professional counseling or psychotherapy elsewhere?

☐ Yes ☐ No

Have you had previous psychotherapy?

☐ No ☐ Yes, with (previous therapist's names) ____________

Do you regularly use alcohol?

☐ Yes ☐ No

In a typical month, how often do you have 4 or more drinks in a 24 hour period?

____

How often do you engage recreational drug use?

☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely ☐ Never

Do you smoke cigarettes or use other tobacco products?

☐ Yes ☐ No

Have you had suicidal thoughts recently?

☐ Frequently ☐ Sometimes ☐ Rarely ☐ Never

Have you had them in the past?

☐ Frequently ☐ Sometimes ☐ Rarely ☐ Never

Are you currently in a romantic relationship?

☐ No ☐ Yes, If yes, how long have you been in this relationship? ______________

On a scale of 1-10 (10 being the highest quality), how would you rate your current relationship?

____

In the last year, have you experienced any significant life changes or stressors?

If yes, please explain: ____

____

Have you ever experienced any of the following?

Extreme depressed mood	☐ No	☐ Yes
Dramatic mood swings	☐ No	☐ Yes
Rapid speech	☐ No	☐ Yes
Extreme anxiety	☐ No	☐ Yes
Panic attacks	☐ No	☐ Yes
Phobias	☐ No	☐ Yes
Sleep disturbances	☐ No	☐ Yes
Hallucinations	☐ No	☐ Yes
Unexplained losses of time	☐ No	☐ Yes
Unexplained memory lapses	☐ No	☐ Yes
Alcohol/substance abuse	☐ No	☐ Yes

Frequent body complaints	☐ No	☐ Yes
Eating disorder	☐ No	☐ Yes
Body image problems	☐ No	☐ Yes
Repetitive thoughts (e.g. obsessions)	☐ No	☐ Yes
Repetitive behaviors (e.g. frequent checking, hand washing	☐ No	☐ Yes
Homicidal thoughts	☐ No	☐ Yes
Suicidal attempts	☐ No	☐ Yes, If yes, when?

OCCUPATIONAL INFORMATION

Are you currently employed?

☐ No ☐ Yes, If yes, who is your currently employer/position?

____

If yes, are you happy with your current position? ______________________________

Please list any work-related stressors, if any ______________________________

____

____

RELIGIOUS/SPIRITUAL INFORMATION

Do you consider yourself to be religious?

☐ No ☐ Yes, If yes, who is your currently employer/position?

If yes, what is your faith? ______________________________

If no, do you consider yourself to be spiritual?

☐ No ☐ Yes

FAMILY MENTAL HEALTH HISTORY

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (circle any that apply and list family member, e.g. sibling parent, uncle, etc.)

DIFFICULTY	YES / NO	FAMILY MEMBER
Depression	☐ No ☐ Yes	
Bipolar disorder	☐ No ☐ Yes	
Anxiety disorder	☐ No ☐ Yes	

Condition	No	Yes	
Panic attacks	☐ No	☐ Yes	
Schizophrenia	☐ No	☐ Yes	
Alcohol/substance abuse	☐ No	☐ Yes	
Eating disorders	☐ No	☐ Yes	
Learning disabilities	☐ No	☐ Yes	
Trauma history	☐ No	☐ Yes	
Suicide attempts	☐ No	☐ Yes	
Chronic illness	☐ No	☐ Yes	

OTHER INFORMATION

What are your strengths? ______________________________

What do you like most about yourself? ______________________________

What are effective coping strategies that you have learned? ______________________________

What are your goals for therapy? ______________________________

Last dental appt ______________________________

Last Physical appt” ______________________________

Last vision appt: ______________________________

Any ongoing appt last visit ______________________________