Artemis COUNSELING

Client Intake Form

Name: _____ Age: _____ Date of Birth: ____/____/____

Address: _____
Street and Number City State Zip

Phone: _____ May we leave a message? ☐ Yes ☐ No

E-mail: _____ May we text message you? ☐ Yes ☐ No

May we email you? ☐ Yes ☐ No

In case of emergency please notify: _____

Phone: _____ Relationship to client: _____

How did you hear about us? ☐ Psychology Today ☐ Yelp ☐ Artemis Counseling ☐ Creative Life
☐ Insurance ☐ Facebook/Social Media ☐ Walked by
☐ Referred by: _____

Briefly tell us about the issues/concerns that have brought you here: _____

_____

_____

_____

What has you seeking therapy at this time? _____

_____

_____

Please check any current or past topics that are relevant to you:

___ Eating disorders/body image
___ Academics or work
___ Finances
___ Outside interests (extracurricular)
___ Perfectionism
___ Technology use
___ Stress/anxiety
___ Phobias (type(s): _____)
___ Sadness/depression
___ Chronic pain/illness (type(s): _____)
___ Childhood abuse (i.e. physical, sexual, emotional)
___ Sexual assault/rape
    ___ Recently (when: _____)
    ___ In the past
___ Alcohol/problematic substance use
___ Gambling
___ Death of someone close
    ___ Recently (when: _____)
    ___ In the past
___ Other: _____

___ Culture/identity
___ Spirituality/religion
___ Dating
___ Trust
___ Sexual health
___ Coming out
___ Transitioning
___ Fertility/pregnancy
___ Parenting
___ Infidelity
___ Domestic violence/abuse
___ Family (ie. divorce, alcoholism)
___ Relationships
    ___ Family
    ___ Friend
    ___ Parent
    ___ Significant other
    ___ Roommate
    ___ Coworker

Medical History

Are you currently under the care of a primary care physician? ☐ Yes ☐ No

If yes, what is your physician's name? _____ Phone: _____

Current medical problems: _____

Current medications (all, including herbal): _____

Are you currently working with a psychiatrist? ☐ Yes ☐ No

If yes, what is your psychiatrist's name? _____ Phone: _____

What is the psychiatrist treating you for? _____

Have you been on any medications in the past for mental health issues? ☐ Yes ☐ No

If yes, please list: _____

Have you previously seen a therapist? ☐ Yes ☐ No Who/Where? _____

How long ago? _____ For what types of issues? _____

Are you currently/recently seeing any kind of therapist/healer? _____

Have you ever been hospitalized for physical or mental health issues? ☐ Yes ☐ No

If yes, briefly describe: _____

Have you had any previous suicide attempts? ☐ Yes ☐ No

If yes, briefly describe: _____

If you are currently experiencing any of the following symptoms, please rate them using the number key below:

Never 0 ***Seldom 1*** ***Often 2*** ***Always 3***

___ Difficulty concentrating
___ Crying
___ Missing work/class
___ Feeling helpless
___ Negativity
___ Feeling uptight/tense
___ Worrying
___ Feeling hopeless
___ Feeling afraid
___ Lying to others
___ Feeling out of control
___ Feelings of self-doubt
___ Injuring self
___ Loneliness
___ Nervousness around others
___ Other: _____

___ Memory loss or blackouts
___ Difficulty sleeping
___ Stealing
___ Anger
___ Jealousy
___ Eating binges
___ Drinking heavily
___ Problematic drug use
___ Feelings of guilt
___ Withdrawing socially
___ Sexual preoccupation/obsessions
___ Low sex drive
___ Suicidal thoughts
___ Physical symptoms (i.e. headaches, digestive)
List: _____
Have you seen a health care provider for these? ___

Is there anything else you'd like us to know about you? _____

_____

_____

Insurance Information: Please fill out the following information if you are paying for your counseling sessions through insurance. These questions refer to the information currently on file with your insurance company.

1. Member name: _____ 2. Member ID#: _____

3. Gender: _____ 4. DOB: _____

5. Address: _____

Street and Number City State Zip