Yvette Brindle-Decancq, LMHC, CPBC
Licensed Mental Health Counselor
Certified Professional Behavioral Coach

CLIENT INTAKE FORM

Please provide the following information to the best of your ability. If the question/section does not apply to you, please write N/A and leave the remainder bland. You may also leave blank any question you would rather not answer, or would prefer to discuss with your therapist. Information you provide here is held to ethical confidentiality standards.

Today's Date: _____

DEMOGRAPHICS

Name: _____ DOB: _____

Address: _____

Phone number(s): _____
May messages be left on phone number(s)? _____ Yes _____No

E-mail address: _____
May this e-mail address to be utilized for appointment reminders?
_____ Yes _____ No

Any information that is sent/received that is HIPPA related or of a personal nature at all MUST be sent via my encrypted e-mail: Yvette.Decancq@rochestertherapist.com

Emergency Contact / Name / Contact Information:
_____

OCCUPATIONAL INFORMATION

Are you currently employed? ( ) no ( ) yes

If yes, who is your current employer/position? _____

How long have you worked in your present position? _____

Please list any work-related stressors, if any

_____

_____

_____

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HEALTH AND SOCIAL INFORMATION

Do you currently have a Primary Care Physician? ( ) yes ( ) no
(If utilizing Excellus BC/BS insurance, this information must be provided. If you do not currently have a PCP, please inform office once you have obtained a provider.)

If yes, please list PCP's name, address, phone number and fax number:

_____
_____
_____
_____
_____
_____
_____ _____

When was your last physical (approximate month/year is appropriate)? _____

Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.) **and if you are currently being treated for such concerns:**

_____
_____
_____
_____
_____

Are you having any problems with your sleep habits? ( ) yes ( ) no

If yes, check where applicable:
( ) Sleeping too little ( ) Sleeping too much ( ) Poor quality sleep
( ) Disturbing dreams ( ) other _____

If yes, please briefly describe sleep issues and if you are being treating behaviorally or with medication for such issues:

_____
_____
_____
_____

How many times per week do you exercise and approximately for how long? _____

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Are you having any difficulty with appetite or eating habits? ( ) Yes ( ) No

If yes, please briefly describe issue and if you are being treated for such issues:

_____
_____
_____

Are you currently seeing more than one mental health/medical health/psychiatric specialist?
( ) Yes ( ) No

If yes, please list provider's name, address, phone number and fax number:

_____
_____
_____
_____
_____
_____

Are you currently seeing more than one mental health/medical health/psychiatric specialist?
( ) Yes ( ) No

If yes, please list provider's name, address, phone number and fax number:

_____
_____
_____
_____
_____
_____

Please list all medications you are currently being prescribed, by whom, and for how long you have been on this medication. ***A printed list from your medical chart is acceptable.***

_____
_____
_____
_____
_____

A Release of Information for the provider(s) listed above must be provided. If there is a reason you do not wish to sign a release, please discuss this at initial intake appointment.

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Substance Related Questions:

Please note this is information for the therapist only in order to work with you most effectively and to offer the most appropriate referral if deemed necessary. It will not be shared without your consent unless treatment is a recommendation which is accepted by you:

Do you use alcohol? ( ) Yes ( ) No

If yes, how often?

_____
_____
_____
_____

How often do you engage in use of **non-prescribed** substances? ( ) daily ( ) weekly ( ) monthly ( ) rarely ( ) never

Which substances do you utilize?

_____
_____
_____
_____

Do you believe that you have an issue with addiction / substance abuse / co-occurring issues? ( ) Yes ( ) No

If you answered yes to previous question, you will be provided a Chemical Use Survey to identify further information related to history of use, chemicals utilized and familial history. Appropriate recommendations and treatment options will be collaboratively agreed upon following completion of survey and discussion with therapist.

For therapist to complete:

_____
_____
_____
_____
_____
_____
_____
_____
_____

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LETHALITY ASSESSMENT:

Have you had suicidal thoughts recently?
( ) frequently ( ) sometimes ( ) rarely ( ) never

Have you had them in the past?
( ) frequently ( ) sometimes ( ) rarely ( ) never

Have you had homicidal thoughts recently?
( ) frequently ( ) sometimes ( ) rarely ( ) never

Have you had them in the past?
( ) frequently ( ) sometimes ( ) rarely ( ) never

Suicidal attempts: Yes / No	**If yes, when?**	**To be discussed with therapist if answered yes.**

Therapist to complete:

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Have **YOU** ever experienced any of the following? Please answer **as accurately** as possible. Exact dates, if unable to obtain, are not necessary.

	Please circle	Date(s)	Briefly describe
Extreme depressed mood	Yes / No		
Dramatic mood swings	Yes / No		
Extreme anxiety/panic attacks	Yes / No		
Phobias	Yes / No		
Hallucinations	Yes / No		
Unexplained losses of time	Yes / No		
Unexplained memory lapses	Yes / No		
Frequent body complaints	Yes / No		
Eating disorder	Yes / No		
Body image problems	Yes / No		
Repetitive thoughts and/or behaviors (e.g. obsessions, frequent checking, frequent hand washing)	Yes / No		

FAMILY MENTAL HEALTH HISTORY

Has anyone in **YOUR FAMILY** experienced difficulties with the following? (Circle any that apply and list family member, e.g. sibling parent, uncle, etc.) Answer to the best of your ability.

Difficulty	Yes / No	Family member
Depression	Yes / No	
Bipolar disorder	Yes / No	
Anxiety disorder	Yes / No	
Panic attacks	Yes / No	
Schizophrenia	Yes / No	

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Alcohol/substance abuse	Yes / No	
Eating disorders	Yes / No	
Learning disabilities	Yes / No	
Trauma history	Yes / No	
Suicide attempts	Yes / No	
Chronic illness	Yes / No	

RELIGIOUS/SPIRITUAL INFORMATION

Do you identify with any organized religion? ( ) yes ( ) no

If yes, what is your faith? _____

If no, do you consider yourself to be spiritual? ( ) yes ( ) no

Any additional information you wish to share:

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TREATMENT PLANNING SECTION

In the last year, have you experienced any significant life changes or stressors? If yes, please briefly explain:

_____

_____

What do you consider to be your strengths?

_____

_____

What are areas in which you feel you'd like to work on in therapy?

_____

_____

What do you currently utilize that you consider to be healthy coping skills?

_____

_____

What are <u>YOUR</u> top three goals for therapy? Please be as specific as possible.

_____

_____

_____

Thank you for taking the time to complete this form.

_____

Client Signature ***Date Completed***

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This page is for use by therapist. Please leave blank.

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