KIM SHAFFER, LCPC COUNSELING SERVICES LLC

2025 Glenwood Avenue

Hermon, ME 04401

207-991-5818

INDIVIDUAL INTAKE FORM

Please answer the following questions to the best of your abilities. This information is held to the same standards of confidentiality as our therapy sessions. This questionnaire will take approximately 30 minutes to complete. Return all pages for your chart.

Name: _____

Birth Date: _____/_____/_____ Age: ____Gender: ____Male ____Female ____Other:

Marital status: ___Single ___Partnered ___Married ___Separated ___Divorced ___Widowed

Number of Children: _____ Ages: _____

Home address: _____

City: _____ State: _____ Zip code: _____

Home phone: _____ May I leave a message? Yes / No

Cell/other: _____ May I leave a message? Yes / No

Email: _____ May I email you?* Yes / No

**NOTE: Emails may not be confidential.*

Referred by: _____

Who currently resides at your home?_____

Have you ever been involved with DHHS? If so, explain._____

Are You currently involved in any legal proceedings? If so, explain._____

Have you served in the military? ___ Yes ___No

Are you currently receiving psychological services, professional counseling, psychiatric services, or any other mental health services? Yes / No

Reason for changing provider: _____

Have you had any mental health services in the past? Yes / No
Reason for changing provider or terminating services: _____

Are you currently taking any psychiatric prescription medications? Yes / No

If yes, please list: _____

Have you been prescribed psychiatric prescription medications in the past? ___ Yes ___ No
If yes, please list: _____

General Health Information

Date of most recent physical:_____ Name of Primary Care Physician:_____

How would you describe your physical health at the present time?
____Poor ____Unsatisfactory ____Satisfactory ____ Good ____ Very good

Please list any persistent physical symptoms or health concerns (e.g., chronic pain, headaches, hypertension, diabetes, thyroid dysfunction, etc.) currently or in the past:
_____

Are you prescribed any medications for physical/medical issues? ___ Yes ___ No
If yes, please list: _____

Are you having any problems with your quality of sleep? __ Yes ___ No If yes, check those that apply: ____ Sleep too much ____ Sleep too little ____ Poor quality ____ Disturbing dreams

How many times per week do you exercise? _____Days _____ Minutes / Hours

Are there any changes or difficulties with your eating habits? ___ Yes ___ No

If yes, check those that apply:
____Eating less ____Eating more ____Binging ____Restricting ____Other: _____

Have you experienced a significant weight change in the last two months? __ Yes __ No
If yes, describe: _____

Do you consume alcohol regularly? ___ Yes ___ No

In the last month, how many times did you have four or more drinks in a 24-hour period?___

How often do you engage in recreational drug use? _ Daily _Weekly _Monthly _Rarely _Never

Are you currently in a substance use program? ___Y __N

Have you experienced symptoms of depression recently? ___ Yes ___ No

If yes, for how long and specific symptoms experienced?

_____

Have you had any suicidal thoughts recently? ___Yes ___ No

If yes, how often? ___Frequently ___ Sometimes ___ Rarely

Have you ever had suicidal thoughts in the past? Yes / No

If yes, how long ago?_____

How often did you have these thoughts? ___Frequently ___ Sometimes ___ Rarely

Are you currently involved in a romantic relationship? ___Yes ___ No

If yes, how long have you been in this relationship? _____

On a scale from 1 to 10 (10 being great, 1 being poor), how would you rate the quality of this relationship? _____

In the last year, have you experienced any major life changes (employment, relocation, relationship, illness, loss of loved one, etc.)? Describe.

_____

Check off any issues below that apply to you:

___ Extreme Depressed Mood ___ Panic Attacks___ Hallucinations___ Alcohol/Substance Use ___ Repetitive Thoughts ___ Repetitive Behaviors___ Suicide Attempts___ Difficulty With Relationships ___ Memory Problems ___ Body Complaints ___ Anxiety___ Homicidal Thoughts ___ Trouble Planning ___ Confusion ___ Extreme Anxiety ___ Sleep Disturbance ___ Eating Disorder ___ Difficulty Communicating___ Indecisiveness ___ Lack of Focus ___ Anger Issues ___ Lack of Motivation___ Mood Swings ____Obsessions/Compulsions ___Lack of Sexual Desire

Other:_____

Employment/Occupational Information

Profession: _____Highest Degree Earned:_____

Current Career Goals:_____ Educational Goals:_____

Are you currently employed? __Yes __ No ___Full Time ___Part Time ___ Unemployment

If employed, who is your employer? _____

What is your current position? _____

Are you happy in your current job/position? ____Yes ___No

Do you feel fulfilled in your current position? ___Yes ___ No

Does your work cause you to feel stressed out? ____Yes ___ No

If yes, what are your work-related stressors? _____

Have you ever been arrested or incarcerated? ____Yes ____No If yes, describe:_____

Do you currently have a Probation Officer?____Yes ___No

Religious/Spiritual Beliefs Information

Do you have any religion or spiritual practices that are important to you? ____Yes ___ No
If yes, what is your faith? _____
If no, do you consider yourself to be spiritual person? _____Yes _____ No

Family Mental Health History

Please provide information about your family mental health history. Circle yes or no if any of your family members have experienced any of the following:

Depression Yes / No **Anxiety Disorders** Yes / No **Bipolar Disorder** Yes / No **Panic Attacks** Yes / No **Alcohol Use** Yes / No **Drug Use** Yes / No **Eating Disorder** Yes / No **Learning Disability** Yes /No **Trauma** Yes / No **Domestic Violence** Yes / No **Obesity** Yes / No **OCD** Yes / No **Schizophrenia** Yes / No **Phobias** Yes/No **Mood Swings** Yes/No **Sleep Disturbance** Yes/No **Inability to Focus** Yes/No **ADHD** Yes/No **Autism** Yes/No **Other:** _____

ABOUT YOU

List 5 of your strengths.

_____
_____
_____

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If employed, who is your employer? _____

What is your current position? _____

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ABOUT YOU

List 5 of your strengths.

_____

_____

_____

List areas of your life you would like to improve upon.

What do you like the most about yourself? What do you like the least about yourself?

What are some ways that you cope with life obstacles and stress?

What are your goals for therapy? What would you like to accomplish during your sessions with me?

Is there anything else you would like to share?

Client's Signature:_____ Date:_____