Integral THERAPY
Blending Psycho-Therapy & Holistic Healing

New Client Intake Form

Date_____ **Intake person**_____

Client Name_____

Date of Birth_____ **Age**_____

Status: Married Single Divorced Widowed Domestic Partner Gender _____

Parent's name (including step parents)_____

_____

Home Address_____

City_____ **State**_____

Zip_____

Preferred phone# Home_____ Cell _____

Email_____

School/grade/teachers name:_____

Referred by_____

Does the client have legal guardianship? If so, please provide a copy of guardianship.

Does the client have an Individualized Education Plan (IEP)? If so, please provide a copy.

Insurance: Yes_____ No_____

Insurance Co_____ **Policy/Plan name**_____

Insurance ID#_____ **Group #**_____

Subscriber_____ **Subscriber date of birth:** _____

Subscriber employer: _____**Relationship to Client** _____

Customer phone service #_____

_____

5133 Washington, Suite 6 Downers Grove, IL 60515
630-398-1023

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Client information:

Brief description of presenting issues:

_____

_____

_____

_____

Is patient under the care of a therapist _____Yes _____NO

Name of therapist _____ How long had client been treated _____

Has the patient ever been hospitalized? ___Yes ___ NO - If so where/when_____

Medications: (Name & Dosage)

_____

_____

Please describe the reason(s) you are seeking counseling at this time:

_____

_____

_____

_____

What have you done in the past to manage the reasons you are seeking counseling?

_____

_____

_____

Please describe significant events in family history: (family changes, moves, losses, etc.)

_____

_____

_____

Family history of mental illness? No _____ Yes _____, if yes who, diagnosis other information:_____

_____

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Describe your main strengths:

_____

_____

Describe your most significant challenges:

_____

_____

What are hoping to gain or accomplish in treatment:

_____

FAMILY INFORMATION

Please list all members of the client's household:

Name	Relationship	DOB	Gender	Occupation/Grade in School

_____

_____

_____

Custody arrangements (if applicable):

_____

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Symptom Checklist

Review the following symptoms and mark the symptoms you are experiencing:

Physical Symptoms:

___ headaches ___ insomnia ___ excessive sweating ___ muscle ache

___ daytime drowsiness ___ increased appetite ___ stomach aches

___ diarrhea/constipation ___ poor appetite

other_____

Behavioral symptoms:

___ increased cigarette use ___cutting ___ low motivation/energy

___ increased alcohol use ___ skin picking ___ excessive energy

___ increased illegal substance use ___ binge eating ___ poor self-care

___ excessive spending ___ impulsive risk taking ___ excessive exercise

___ restricting food intake ___ avoiding social contacts ___ hair pulling

___ poor concentration ___ forgetfulness ___ purging

Other_____

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Emotional Symptoms:

___ easily frustrated ___ cry easily ___ changing moods ___ anger ___ worried

___ thoughts of suicide ___ feel something bad will happen ___ hopeless

___ thoughts of homicide ___ intrusive/upsetting thoughts ___racing thoughts

___ irritable ___ scared ___ lonely ___ sad

other_____

Has your child experienced any of the following problems at school:

___ Emotional ___ poor grade ___ detention ___ Behavior problems

___ fighting ___ lack of friends ___stomach aches ___ poor attendance

___ suspension ___ bullying ___ learning disabilities ___ incomplete homework

other_____

Do you currently feel suicidal?_____ Do you have a plan and a means to kill yourself? _____

Do you currently feel homicidal?_____ Do you have a plan and a means to kill someone else?_____

Other information:

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