

Julie Perez, LCSW
Inner Wisdom Counseling

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Client Intake

Name: _____ Today's Date: _____

Age: _____ Date of Birth: _____ Marital Status: _____

Home Address: _____

Mailing Address: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Fax: _____

Email Address: _____

Emergency Contact Name & Number: _____

Your Occupation: _____ Employer: _____

Whom do you live with?	Name	Age	Occupation/School
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Spouse/Partner: _____

Children: _____

Other: _____

Concerns that bring you to therapy: _____

When did your current symptoms first appear? _____

First date of same or similar symptoms: _____

Goals for Therapy: (What would you like to accomplish in therapy?)

Whom do you rely on for emotional and practical support: _____

Do you have a spiritual practice or church connection? (Please Describe):

HEALTH CARE INFORMATION AND MEDICAL HISTORY:

Prior hospitalizations or major surgeries (include year): _____

Serious illnesses/injuries/allergies: _____

Current medications (name & dosage): _____

Smoker? Y N How much? _____ Alcohol use? Y N How much? _____

Other drug use? Y N Type and amount/frequency? _____

Family Medical History (please list any major health problems or alcohol/drug problems of any immediate or extended family members, and indicate relationship of the person to you):

MENTAL HEALTH HISTORY:

Prior Therapy? Y N When? _____ Purpose of Therapy? _____

Was your prior therapy helpful and if so how? _____

Have you ever been given a mental health diagnosis? Y N Please list and state if you agree with the diagnosis:

Prior suicidal thoughts or attempts? Y N If so, explain _____

Are you currently suicidal? Y N If so, explain _____

Prior/present thoughts or attempts to harm yourself or others? Y N If so, explain _____

Have you ever been hospitalized for mental health reasons? Y N If so, when/where: _____

Family Mental Health History (please list any mental health problems/diagnoses or suicidal attempts you are aware of for any immediate or extended family members, and indicate relationship of the person to yourself): _____

PROBLEMS YOU FEEL APPLY TO YOU (Please check those that apply to you and explain when indicated):

- | | |
|---|---|
| <input type="checkbox"/> Abandonment | <input type="checkbox"/> Abuse (explain: _____) |
| <input type="checkbox"/> Affair (explain: _____) | <input type="checkbox"/> Alcohol |
| <input type="checkbox"/> Alienation | <input type="checkbox"/> Anger |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Avoidant |
| <input type="checkbox"/> Appetite (increase ___ decrease ___) | <input type="checkbox"/> Blended Family |
| <input type="checkbox"/> Body Image | <input type="checkbox"/> Bonding |
| <input type="checkbox"/> Boundaries | <input type="checkbox"/> Codependency |
| <input type="checkbox"/> Communication | <input type="checkbox"/> Compulsive Eating |
| <input type="checkbox"/> Compulsions | <input type="checkbox"/> Concentration |
| <input type="checkbox"/> Crisis (explain: _____) | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Disability (explain: _____) | <input type="checkbox"/> Distractible |
| <input type="checkbox"/> Distressing Dreams | <input type="checkbox"/> Distressing Memories |
| <input type="checkbox"/> Divorce | <input type="checkbox"/> Domestic Violence (actual or threatened) |
| <input type="checkbox"/> Drugs | <input type="checkbox"/> Eating Disorder (explain: _____) |
| <input type="checkbox"/> Emotionally Numb | <input type="checkbox"/> Employment (explain: _____) |
| <input type="checkbox"/> Emptiness | <input type="checkbox"/> Enabling (explain: _____) |
| <input type="checkbox"/> Family Conflict (explain: _____) | <input type="checkbox"/> Fatigue/Low Energy |

- | | |
|---|---|
| <input type="checkbox"/> Fears (explain: _____) | <input type="checkbox"/> Financial Stress |
| <input type="checkbox"/> Grief (explain: _____) | <input type="checkbox"/> Guilt (explain: _____) |
| <input type="checkbox"/> Hallucinations (visual or auditory) | <input type="checkbox"/> Hopelessness |
| <input type="checkbox"/> Hyperactive | <input type="checkbox"/> Idealizations |
| <input type="checkbox"/> Inactivity | <input type="checkbox"/> Inhibitions |
| <input type="checkbox"/> Impulsivity | <input type="checkbox"/> Irritability |
| <input type="checkbox"/> Isolation | <input type="checkbox"/> Jealousy |
| <input type="checkbox"/> Legal Problem (explain: _____) | <input type="checkbox"/> Marital |
| <input type="checkbox"/> Medical (explain: _____) | <input type="checkbox"/> Memory Loss |
| <input type="checkbox"/> Mood Swings | <input type="checkbox"/> Obsessions |
| <input type="checkbox"/> Pain (explain: _____) | <input type="checkbox"/> Panic Attacks |
| <input type="checkbox"/> Rage | <input type="checkbox"/> Rationalizations |
| <input type="checkbox"/> Rejection | <input type="checkbox"/> Relationships |
| <input type="checkbox"/> Self Absorption | <input type="checkbox"/> Self-Esteem |
| <input type="checkbox"/> Sexual Abuse | <input type="checkbox"/> Shame |
| <input type="checkbox"/> Sibling Conflict | <input type="checkbox"/> Social Skills |
| <input type="checkbox"/> Sleep (explain: _____) | <input type="checkbox"/> Suicidal (Thoughts or Actions) |
| <input type="checkbox"/> Trauma/Life Threatening Event (explain: _____) | |
| <input type="checkbox"/> Trust | |
| <input type="checkbox"/> Weight Change (explain: _____) | |
| <input type="checkbox"/> Worry | |
| <input type="checkbox"/> Other (explain: _____) | |

Thank-you for your willingness and time to provide this personal information

Client Signature

Date