CLIENT INTAKE FORM

Free Your Mind Therapy Services, LLC
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850-637-7033

Please provide the following information for our records. Leave blank any question you would rather not answer, or would prefer to discuss with your therapist. Information you provide here is held to the same standards of confidentiality as our therapy.

Name: _____ Todays Date: _____

Date of Birth: _____ Gender: _____

Address: _____
City: _____ State: _____ Zip: _____
Email: _____

Marital Status: _____
Telephone: Cell:_____Home:_____Work:_____

Employer: _____

Occupation:_____
Emergency Contact Name: _____
Emergency Contact Ph #: _____
Emergency Contact Relationship: _____
Would you prefer appointment reminders by: (circle one) Text Email None

Referred by: _____

TREATMENT HISTORY

Are you currently receiving psychiatric services, professional counseling or psychotherapy elsewhere? ( ) yes ( ) no

Have you had previous psychotherapy?
( ) no
( ) yes, with (previous therapist's name)_____

Are you currently taking prescribed psychiatric medication (antidepressants or others)? ( ) yes ( ) no

If yes, please list: _____

Prescribed by: _____

HEALTH AND SOCIAL INFORMATION

Do you currently have a primary physician? ( ) yes ( ) no

If yes, who is it? _____

Are you currently seeing more than one medical health specialist? ( ) yes ( ) no

If yes, please list: _____

When was your last physical? _____

Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.: _____

_____

Are you currently on medication to manage a physical health concern? If yes, please list: _____
_____

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

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions Code, Civil Code and HIPPA Privacy Standards. Duplication of this information for further disclosure is prohibited without prior written authorization of the client/ authorized representative to who it pertains unless other permitted by law.

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

How many times per week do you exercise? _____

Approximately how long each time? _____

Are you having any difficulty with appetite or eating habits? ( ) no ( ) yes

If yes, check where applicable: ( ) Eating less ( ) Eating more ( ) Bingeing
( ) Restricting

Have you experienced significant weight change in the last 2 months? ( ) no ( ) yes

Do you regularly use alcohol? ( ) no ( ) yes

In a typical month, how often do you have 4 or more drinks in a 24 hour period?

_____

How often do you engage recreational drug use? ( ) daily ( ) weekly ( ) monthly
( ) rarely ( ) never

Do you smoke cigarettes or use other tobacco products? ( ) yes ( ) no

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

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

Are you currently in a romantic relationship? ( ) no ( ) yes

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

On a scale of 1-10 (10 being the highest quality), how would you rate your current relationship? _____

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

_____

Have you ever experienced any of the following?

Extreme depressed mood	Yes / No
Dramatic mood swings	Yes / No
Rapid speech	Yes / No
Extreme anxiety	Yes / No
Panic attacks	Yes / No
Phobias	Yes / No
Sleep disturbances	Yes / No
Hallucinations	Yes / No
Unexplained losses of time	Yes / No
Unexplained memory lapses	Yes / No
Alcohol/substance abuse	Yes / No
Frequent body complaints	Yes / No
Eating disorder	Yes / No
Body image problems	Yes / No
Repetitive thoughts (e.g. obsessions)	Yes / No
Repetitive behaviors (e.g. frequent checking, hand washing	Yes / No
Homicidal thoughts	Yes / No
Suicidal attempts	Yes / No If yes, when?

OCCUPATIONAL INFORMATION

Are you currently employed? ( ) no ( ) yes

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

If yes, are you happy with your current position? _____

Please list any work-related stressors, if any _____

_____

_____

RELIGIOUS/SPIRITUAL INFORMATION

Do you consider yourself to be religious? ( ) no ( ) yes

If yes, what is your faith? _____

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

FAMILY MENTAL HEALTH HISTORY

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (circle any that apply and list family member, e.g. sibling parent, uncle, etc.)

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

OTHER INFORMATION

What do you consider to be your strengths? _____

_____

_____

What do you like most about yourself? _____

_____

What are effective coping strategies that you have learned? _____

_____

_____

What are your goals for therapy?

_____

_____

_____

_____

Individual counseling sessions are $80 per 50-minute individual session. Extended sessions are usually recommended for couples and family work and can sometimes be helpful for individual therapy, as well. A 90 minute individual session is $100 per session. For a couples 50 minute 2 person session, the fee is $100. For a 90 minute 2 person session session the fee is $155. If you believe a modified session length would be appropriate for you, please discuss this with your therapist. Paying by cash or check allows a discount of $4 for a 50-minute individual session and $5 for a 90-minute individual session and $7.75 for a 2 person 90 minute session.

Financial Agreement and Authorization to Charge Credit Card

• Session fees are due at the time of service.

• Any appointments scheduled ***but not kept***, as well as any appointments cancelled

within 48 hours of scheduled time will be charged at the full session fee. **($80 for a 50 minute individual session / $100 for 90 minute individual session. The fee for a 2 person 50-minute session is $100 / $155 90-minute session) including the processing fees listed above.**

Client Name: _____

Date of Birth: _____

- I authorize Free Your Mind Therapy Services, LLC to charge my credit card for office charges.
- I understand that if my credit card does not accept the charge, I will immediately make payment to the practice.
- I understand that I may cancel this authorization at any time, but by doing so, I acknowledge that the balance owed will be due & paid in full.
- I acknowledge that credit card transactions could be linked to Protected Health Information.

_____ _____

Signature of Card Holder Date