CHRISTINE SPERRAZZA
LCMHC, PLLC

Psychotherapy

Clinical Intake Form

Client Contact Information

First Name:_____ Last Name:_____ Date:_____

Address:_____

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

Reason for starting therapy:

_____
_____
_____

Goals you want to accomplish in therapy:

_____
_____
_____

In the last year, have you experienced any significant life changes or stressors? If so, please describe:

_____
_____
_____

Family Information and History

Currently in a significant romantic relationship? YES NO

Significant prior relationships (divorced, widowed, etc.)? _____

Number of children and ages (if applicable):_____
_____

Pets? Yes No Name and type (dog, cat, etc.):_____

Employment/Education History

Job Title:_____ Current Employer:_____

When did you start this job?: _____ How many hours a week do you work?:_____

Current employment concerns (if applicable):_____
_____
_____

Degree (if applicable): _____
Current level in school (if applicable):_____

Educational concerns (if applicable):_____
_____
_____

Medical History

Please list any **current** medical problems (gastrointestinal, thyroid disorder, headaches, etc.). Include all medications you are currently taking and the name of the doctor who prescribes the medication. Please include information regarding being followed by a doctor for any reason now or in the past.

_____
_____
_____
_____
_____

Please list any significant medical history with dates (cancer, accidents, surgeries, etc.):

_____
_____
_____
_____

Please list any accommodations needed (wheelchair access, etc.):

_____
_____

Do you have allergies to anything (medications, food, etc.)?:

_____
_____
_____

Are you experiencing sleep problems? If so, please describe: _____
_____

Do you have a history of eating problems or are you currently struggling with food and/or weight issues? _____

How frequently do you exercise?_____

Any other medical concerns not covered above?

Mental Health Treatment History

Have you been in therapy before? YES NO

If yes, when and under what circumstances? _____

Previous therapist(s) name(s):_____

Have you ever had a crisis assessment or been hospitalized for mental health reasons? If so, when:

_____

_____

Do you ***currently*** feel hopeless or have suicidal thoughts? _____
In the past?_____
Have you ever had a suicide attempt? If so, when?

_____

Have you experienced trauma recently or in the past (abuse, accidents, etc.)?

_____

_____

Current Substance Use History and Frequency (Circle):

Alcohol:	Daily	Weekly	Monthly
Cigarettes:	Daily	Weekly	Monthly
Marijuana:	Daily	Weekly	Monthly
Other:	Daily	Weekly	Monthly

Are you now or have you previously been a member of a substance abuse program or support group (circle one)? YES NO

Have you previously been treated for substance abuse (circle one)? YES NO

Legal

Have you ever been arrested? YES NO

If yes, please describe charges and outcome, including dates:

_____

Do you currently have an assigned probation officer *and/or* social worker? YES NO
If yes, please list name:_____

Are you currently involved in a divorce and/or custody situation? YES NO
Are you currently being threatened or hurt by another person? YES NO

Other

What are your hobbies, interests, healthy habits, and strengths?

_____
_____
_____

What are the areas you would like to improve?

_____
_____
_____

Please list any other information not listed on this form that you feel is pertinent to my working with you:

_____
_____
_____
_____
_____
_____
_____

For Therapist To Complete:

Mental Status Examination (Presentation During Initial Interview):

Appearance- *Thought Process and Content-*

Behavior- *Thought Control-*

Speech- *Cognition/Intellectual Resources-*

Mood- *Insight/Judgment-*

Affect- *Orientation-*

Presenting Problem (precipitant, onset, duration, severity, impact on functioning, history) and Assessment (including diagnosis, stressors, strengths, and prognosis):

Treatment Plan/Goals/Time Frame/Discharge Plan:

Family Tree/History: