RELIEVE BEHAVIORAL HEALTH AND WELLNESS CENTER

CLIENT INTAKE FORM

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.

DEMOGRAPHICS

Name: _____

Preferred name if different:

Social Security Number: _____-_____-_____ DOB---------- _____

Address (City, State &Zip):_____

Phone: _____ Email: _____

Referred by: _____Ethnicity: _____ Preferred Language: _____

Marital Status: Single Engaged Married Separated Divorced Widowed

Please circle Yes or No for the following:

Are you pregnant or planning on getting pregnant: Yes or No?

Veteran: Yes or No?

DCF Involvement: Yes or No?

Allergies (medication & food): _____

Preferred Pharmacy:_____

Occupation: _____Place of Employment: _____

Emergency Contact Name: _____Phone: _____

Relationship: _____

INSURANCE

Plan Name: _____

Member ID: _____Relationship to Primary Policy Holder: _____

Policy holders Name: _____

Date of Birth: _____

Do you have a secondary insurance plan: Yes or No?

281 Hartford Turnpike
Suite #504, Vernon, CT 06066
Phone: 860-995-4268
Fax: 860-838-7600

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TREATMENT HISTORY

Have you ever received psychological, psychiatric, drug or alcohol services? Yes or No?
Please circle: Inpatient Outpatient Both
When: _____ Where: _____
For What: _____

Have you had suicidal thoughts recently? (_) frequently (_) sometimes (_) rarely (_) never
Have you ever attempted suicide? Yes or No?
Have you ever attempted self-injurious behavior? Yes or No?
Please explain YES answers:

_____

_____

Are you currently engaged in THERAPY? Yes or No? Therapist Name: _____
Past or current medication prescriber name: _____

HEALTH INFORMATION

Do you currently have a primary care physician? Yes or No?

Physician Name: _____ Date of last visit: _____
When was your last physical? _____
Are you currently seeing more than one medical health specialist? Yes or No?
Please list any persistent physical symptoms or health concerns
(e.g. chronic pain, headaches, hypertension, diabetes, etc.):

_____

_____

Please list any previous surgical procedures:

_____

_____

Please list all medications include herbal or over the counter that you are currently taking:

_____

_____

_____

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Are you currently being treated for PAIN? Yes or No?
Are you having any problems with your sleep habits? Yes or No?
If yes, check where applicable:
( ) Sleeping too little ( ) Sleeping too much
( ) Poor quality sleep ( ) Disturbing dreams ( ) other _____
How many hours per night do you sleep? _____

Are you having any difficulty with appetite or eating habits? Yes or No?
If yes, check where applicable: ( ) Eating less ( ) Eating more ( ) Bingeing ( ) Restricting
Have you experienced significant weight change in the last 6 months? Yes or No?

SOCIAL INFORMATION

Do you regularly use alcohol? Yes or No?
How many days per week do you consume alcohol? _____
Do you consume more than 4 drink in a 24-hour period? Yes or No?
Do you use marijuana or any marijuana products? Yes or No?
Do you have a history of problematic use of prescription or non-prescription drugs? Yes or No?
Do you smoke cigarettes or use other tobacco products? Yes or No? Packs per day:_____

ABUSE HISTORY

Physical Abuse: Yes or No?
Reported to DCF/law enforcement? Yes or No?
Comments: _____
Sexual Abuse: Yes or No?
Reported to DCF/law enforcement? Yes or No?
Comments: _____
Emotional Abuse: Yes or No?
Reported to DCF/law enforcement? Yes or No?
Comments: _____
Abusive Relationship (spouse, significant other, boyfriend/girlfriend) Yes or No?
Reported to DCF/law enforcement? Yes or No?
Comments: _____

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Legal Issues

Regarding current treatment, are there any legal issues involved or workers compensation? Yes or No?
Will a report on your progress in therapy be required? Yes or No?
If yes, please explain: _____
To Whom?_____
Address:_____
Please describe any past or current involvement in court proceedings:
_____
_____

SYMPTOMS

Please Check any or ALL symptoms you are experiencing at this time:

Symptom	Check here	Symptom	Check here
Fatigue		Sleeping to much	
Anxiety		Sleeping to little	
Nervousness		Nightmares	
Panic Attacks		Anger	
Phobias		Isolation	
Sleep Disturbances		Repetitive thoughts/Behaviors	
Sadness		Mood Swings	
Extreme Depressed mood		Rapid Thoughts	
Appetite changes		Concentration Issues	
Weight Changes		Abuse Sexual, Physical, Emotional	
Body Image problems		Unexplained memory loss	
Eating disorders		Alcohol/Substance abuse	
Guilt		Pain	
Stress		Hallucinations	
Suicidal gestures/Thoughts		Homicidal Thoughts	

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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	**Circle one**	**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	

Any addition comments or concerns your provider should know:

_____

_____

_____

_____ _____

Signature Date

_____

Legal Guardian Print and Sign Date

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