heather b. rensmith, lcsw

INTAKE

Please provide the following information for our records. Leave blank any question you would rather not answer. Information you provide here is held to the same standards of confidentiality as our therapy. Please print out this form, complete it and bring it to your first session or allow yourself 15 minutes prior to your appointment to complete the form in the office.

Legal name: _____

Birth Date: _____ /_____ /_____ Age: _____

Gender Identification: ▫ Cis Female ▫ Cis Male ▫ Transgender:_____

Correct Pronoun: _____

Correct Name: _____

Address:

_____

_____

Cell/ Home Phone: _____

May I leave a msg? ▫Yes ▫No

E-mail: _____

May I email you? ▫Yes ▫No *Please be aware that email might not be confidential.

Emergency Contact – Please list name, number(s) and relationship:

_____

If you are planning to use your insurance benefits, please complete the following section:

Insured's ID Number:_____

Insured's Group Number:_____

Insured's Name: _____

Insured's DOB: _____

Relationship to Insured: _____

Insurance Plan/Program Name and Number:_____

_____

OCCUPATIONAL INFORMATION

Are you currently employed? ▫ No ▫ Yes, current employer/position?_____

If yes, are you happy at your current position?

_____

Please list any work-related stressors, if any:

_____

HEALTH AND SOCIAL INFORMATION

1. Please list any current physical symptoms or health concerns (chronic pain, headaches, diabetes, etc.)

_____

_____

_____

2. Please list if condition is related to employment, auto accident or other accident:

_____

3. Are you currently receiving psychiatric services or counseling elsewhere? ▫Yes ▫No

Current providers name: _____

4. Previous therapist's/psychiatric provider name_____

5. Are you currently taking any medication or supplements (psychiatric or others)?

▫Yes ▫No

If yes, please list:

_____

_____

_____

6. Are you having any problems with your sleep habits? ▫Yes ▫No

▫ Sleeping too little ▫ Sleeping too much ▫ Poor quality sleep ▫ Disturbing dreams
Other_____

7. Do you exercise? ▫Yes ▫No

How frequent?

_____

8. Are you having any difficulty with appetite or eating habits? ▫Yes ▫No

If yes, check where applicable: ▫ Eating less ▫ Eating more ▫ Binging ▫ Restricting

Have you experienced significant weight change in the last 2 months? ▫Yes ▫No

9. Do you regularly use alcohol? ▫Yes ▫No

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

_____

10. How often do you engage recreational drug use? ▫ Daily ▫ Weekly ▫ Monthly ▫ Rarely ▫ Never

11. Have you had thoughts of harming yourself or others? ▫Yes ▫No

_____

12. Have you ever tried to harm yourself or others? ▫Yes ▫No

_____

13. Are you currently in a romantic relationship(s)? ▫Yes ▫No

If yes, how long have you been in this/these relationship(s)?

_____

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

_____

14. Which best describes your current or most recent relationship: ▫ married ▫ single ▫ partnered ▫ open/poly/swing ▫ monogamous ▫ separated ▫ divorced ▫ widowed ▫ other _____

15. In the last year, have you experienced any significant life changes or stressors:

_____

_____

16. Please list all current emotional concerns:_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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.):

Depression
Anxiety
Schizophrenia
Eating Disorders
Trauma History
Bipolar Disorder
Panic Attacks
Alcohol/Substance Abuse
Learning Disabilities
Suicide Attempts

RELIGIOUS/SPIRITUAL INFORMATION

Do you consider yourself to be religious/spiritual? ▫ No ▫ Yes

If yes, what is your faith/religion/spiritual path?

_____

_____

OTHER INFORMATION

What do you consider to be your strengths?

_____

_____

What are effective coping strategies that you've learned?

_____

_____

What are your goals for therapy?

_____

_____

_____

_____

_____

_____

_____

_____