Mending Hearts Counseling

Intake Form

Mending Hearts Counseling and your psychotherapist ask that you complete this form to the best of your ability. While you are not required to supply the information requested, know that the more information you provide, the better Mending Hearts Counseling will be able to meet your specific needs. This information may be considered confidential; however, certain otherwise confidential information may be shared as required by law. The completed intake form will be kept in the client file and maintained under the same confidentiality protections as the therapeutic record, as detailed in the Mending Hearts Counseling Disclosure Statement and HIPAA Form.

Demographics & Contact Information

_____ _____
Client Name Date

_____
Street Address, City, State, Zip

Mobile Phone: _____ OK to leave a message? **Y or N**
Home Phone: _____ OK to leave a message? **Y or N**
Work Phone: _____ OK to leave a message? **Y or N**
Email*: _____ OK to email you? **Y or N**

**See the Mending Hearts Counseling Release of Information consent form before agreeing to receive communication via electronic means.*

_____ _____
Emergency Contact Emergency Phone

Relationship to Client:_____

_____ _____ Gender: ☐Male ☐Female ☐Other: _____
Client Date of Birth Current Age

Relationship Status (check all that apply): ☐Single ☐Married ☐Cohabitating ☐Divorced ☐Separated ☐Widow/er ☐Engaged or Other: _____

Ethnicity: _____

Employer/School: _____ Occupation/Studying_____

Health Insurer: _____

Household Annual Income: _____ (*Only needed for sliding scale purposes)*

_____ _____
Physician Name Phone

When was your last doctor's visit?_____

_____ _____
Psychiatrist/Prescriber Name Phone

_____ _____
Previous Counselor Name Phone

Please note that in accordance with applicable HIPAA and Colorado regulations, we will not contact your physician, psychiatrist, or counselor without your knowledge and consent.

How did you hear about Mending Hearts Counseling?
_____
_____
_____

Current Concerns

What led you to seek counseling?
_____
_____
_____
_____
_____
_____
_____
_____

In the past, what has been helpful for you in dealing with this issue?
_____
_____
_____

Among your friends and family, who provides support (physical, emotional, spiritual, financial, etc.)?
_____
_____
_____

What part does faith, religion, or spirituality play in your life?
_____
_____
_____

Do you attend a place of worship? ☐ YES ☐ NO If so, where?
_____

Danger to Self or Others

Have you ever had thoughts of harming yourself or others? ☐ YES ☐ NO If yes, please explain:
_____
_____

Have you ever seriously considered suicide or attempted suicide? ☐ YES ☐ NO If yes, explain:
_____
_____

Do you have the intent and means to commit suicide now? ☐ YES ☐ NO If yes, explain:
_____
_____

Do you have the intent and means to harm or kill someone other than yourself right now?
☐ YES ☐ NO If yes, explain: _____

Medical and Mental Health History

Are you experiencing any physical symptoms such as over/under eating, sleeping problems, chest pain, anxiety, depression, shortness of breath, etc.? ☐ YES ☐ NO If yes, please explain:
_____
_____
_____
_____
_____
_____
_____
_____

Are there any significant past or present **health or medical** issues that we should be aware of?
☐ YES ☐ NO If yes, please explain: _____
_____
_____
_____

Are there any significant past or present **mental health** issues that we should be aware of? ☐ YES ☐ NO If yes, please explain: _____
_____
_____
_____

Are there any significant past or present **developmental** issues that we should be aware of? ☐ YES ☐ NO If yes, please explain: _____
_____
_____

Have you ever experienced **abuse** (emotional, physical, and/or sexual)? ☐ YES ☐ NO If yes, please describe, to include dates and relationship of the abuser: _____
_____
_____

Have you ever experienced other types of **trauma**, to include head injury/concussion? ☐ YES ☐ NO If yes, please describe: _____
_____
_____

Have you ever experienced **flashbacks** concerning trauma**?** ☐ YES ☐ NO If yes, please describe:
_____
_____
_____

Have you ever suffered from any type of **eating disorder**? ☐YES ☐ NO If yes, please describe:
_____
_____
_____

Medication, Substance Use, and Addiction

Please list all medications you are now taking and/or have taken in the <u>past 3 months</u>:

Medication	Dosage	Prescriber	How long?	Helpful?	Comments

Please indicate whether you use (or have used in the past) the following substances:

Tobacco: ☐ YES ☐ NO Starting age/extent: _____
Marijuana: ☐ YES ☐ NO Starting age/extent: _____
Drugs: ☐ YES ☐ NO Starting age/extent: _____
Drug(s) of choice: _____
Alcohol: ☐ YES ☐ NO Drinks per week: _____
Drink(s) of choice: _____
Other: ☐ YES ☐ NO Starting age/extent: _____
Substance(s) of choice: _____

Do you have other substances that you have had difficulty abstaining from such as food, gambling, shopping, pornography, etc.? ☐ YES ☐ NO If yes, please explain:_____
_____
_____
_____

Family of Origin

Describe your immediate family (e.g. parents, siblings, ages, etc.): _____
_____
_____
_____
_____

Does your family, whether biological or adopted, struggle with mental illness, chemical dependency, suicidality, etc.? ☐ YES ☐ NO If yes, please explain:
_____
_____
_____
_____
_____

Sleep	No problems	Trouble falling asleep	Trouble waking	Nightmares
Appetite	Normal	Not hungry	Always hungry	Variable
Energy	No problems	Low	Hyper	Variable
Memory	No problems	Excellent	Average	Not good
Interested in sex	Low	High	Normal	Variable
Feeling Depressed	Not at all	Sometimes	Frequently	All the time
Feeling Anxious	Not at all	Sometimes	Frequently	All the time
Panic Attacks	Not at all	Sometimes	Frequently	All the time
Exercise	Not at all	Infrequent	Average	A lot
Anger	Not at all	Sometimes	Frequently	All the time

Relationship Status

Describe your relationship with your current partner. Please include how long you have been together and/or married: _____
_____
_____
_____

What are the strengths of your relationship? _____
_____
_____

What are the weaknesses of your relationship? _____
_____
_____

Children

Please list and describe your children (living and deceased) indicating whether biological, step, adopted, foster, etc.

Name	Age	Gender	With you?	Status/Comments

Sentence Completion

I came here today _____
My relationship is _____
I am really happy when _____
I feel mad when _____
I wish _____
Growing up in my family _____
If I could change one thing _____
Six months from now _____

Additional Questions

If you have had therapy before, what worked best for you? What would you have changed?

_____
_____
_____

How will you know that therapy has been a success?

_____
_____
_____

What do you want life to look like upon the completion of therapy?

_____
_____
_____

Is there anything else we need to know to better assist you?

_____
_____
_____

Signatures

By signing below, you certify the above information are truthful and accurate to the best of your ability, and you authorize Mending Hearts Counseling to begin mental health/relational health therapy.

_____
Client Printed Name

_____ _____
Client Signature Date

_____
Therapist Printed Name, Credentials

_____ _____
Therapist Signature Date