Jess Logan, LCSW
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Client Intake

Please fill in the information below. Please note: information provided on this form is protected as confidential information.

Personal Information

Name:_____ Date: _____
Parent/Legal Guardian (if under 18): _____

Address: _____

Phone: _____ May we leave a message? □ Yes □ No

Email: _____ May we leave a message? □ Yes □ No *Please note: Email correspondence is not considered to be a confidential medium of communication.

DOB: _____ Age: _____ Gender: _____

Martial Status: □ Never Married □ Domestic Partnership □ Married □ Separated □ Divorced □ Widowed

Referred By (if any): _____

Please briefly describe why you are coming to therapy:

_____

Please check the box if you have recently been bothered by the following symptoms:

Little interest in doing things		Partner/Marital conflicts	
Feeling down, depressed		Family conflicts	
Trouble sleeping		Conflict at work	
Poor appetite		Conflict at home	
Low energy		Sexual Concerns	
Low Self-esteem		Gender identity concerns	
Worrying a lot		Stomach pain	
Feeling anxious or on edge		Headaches	
Anxiety/panic attack		Nightmares	
Anger/Irritability		Flashbacks	
Suicidal thoughts		Avoidance of places or memories	

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)? Circle: No Yes

If yes, please list time period: _____

Previous therapist/practitioner: _____

Any prior diagnosis that you are aware of? _____

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Have you ever been prescribed psychiatric medication? □ Yes □ No If yes, please list and provide dates:
_____

In the section below, identify if there is a family history of any of the following for yourself AND/OR a family member. If yes, please indicate the family member's relationship to you in the space provided (e.g. father, grandmother, uncle, etc.)

	Please Circle:	Myself:	Family member:
Alcohol/Substance Abuse	Yes / No		
Anxiety	Yes / No		
Depression	Yes / No		
ADHD	Yes/No		
Domestic Violence	Yes / No		
Eating Disorders	Yes / No		
Obsessive Compulsive Behaviors	Yes / No		
Schizophrenia/Psychosis	Yes / No		
Suicide Attempts	Yes / No		

Health Information

1. How would you rate your current physical health? (Please circle one)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:
_____

2. How would you rate your current sleeping habits? (Please circle one)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:
_____

3. How many times per week do you generally exercise?
_____

4. What types of exercise do you participate in?
_____

5. Please list any difficulties you experience with your appetite or eating:
_____

6. Are you currently experiencing feelings of sadness, grief or depression? Circle: No Yes

If yes, for approximately how long?_____

Have you ever felt this way in the past? If so, when?_____

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7. Any current self-harm behaviors? Any current suicidal thoughts? _____

8. Are you currently experiencing anxiety, panics attacks or have any phobias? Circle: No Yes

If yes, when did you begin experiencing this? _____

9. Do you have a history of any traumatic experiences, or prior abuse your life? Circle: No Yes

If yes, please briefly describe: _____

10. What significant life changes or stressful events have you experienced recently? _____
_____

11. Are you currently experiencing any chronic pain? Circle: No Yes

If yes, please describe: _____

12. Do you drink alcohol more than once a week? Circle: No Yes

Any concerns related to your drinking? _____

13. How often do you engage in recreational drug use?

□ Daily □ Weekly □ Monthly □ Infrequently □ Never

Please list drugs used:_____

14. Are you currently in a romantic relationship? Circle: No Yes

If yes, for how long? _____

On a scale of 1 (poor)-10 (exceptional), how would you rate your relationship? _____

Any specific relationship concerns? _____

Additional Information

1. Are you currently employed? Circle: No Yes
   If yes, what is your current employment situation?
   _____
   Do you enjoy your work? Is there anything stressful about your current work?
   _____
2. Are you currently in school? If so, what are you studying? If not, what was the last level of education you completed?
   _____
3. What do you consider to be some of your strengths?
   _____
4. What do you consider to be some of your weaknesses?
   _____
5. What do you hope to accomplish out of your time in therapy?
   _____
   _____