CLIENT PERSONAL DEMOGRAPHICS AND INTAKE QUESTIONNAIRE

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Client Information **Today's Date**_____

Client's First Name: Middle Initials: Client's Last Name:

_____ _____ _____

Preferred Name Client Date of Birth Client's Sex Assigned at Birth

_____ _____ _____

Client's Gender Identity Client's Sexual Orientation Client's Preferred Pronouns

_____ _____ _____

Client's Cultural Identity (race and/or ethnicity)

_____

Client's Marital Status: Single ____ Married ____ Partner ____ Separated ____ Divorced ____ Widowed ____

Client's Address _____

City _____ State _____ Zip _____

Birthplace (City/State/Country) _____

Home Phone _____ Cell Phone _____ Work Phone _____

May we leave a message at the listed phone number(s)? Yes ____(please circle) No ____

Would you like reminder messages via text? Yes ____ No ____

Client's Email _____

Referred by _____

May I thank this individual for the referral? Yes ____ No ____

Responsible party information (IF OTHER THAN CLIENT) or Guardian (IF CLIENT IS A MINOR):

Relationship to client _____

First Name _____ MI _____ Last Name _____

Address _____

City _____ State _____ Zip _____

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The self-pay fee for a 50-minute, individual psychotherapy initial consultation is $150.00. All following 50-minute, individual visits are $130.00.

The self-pay fee for a 50-minute, couples or family counseling initial consultation is $175.00. All following 50-minute couples or family counseling visits is $150.00.

The self-pay fee for 90-minute Brainspotting therapy sessions is $190.00.

I have reviewed the Introduction to Psychotherapy and Financial Agreement information, I agree to pay agreed-upon fees, and I voluntarily agree to participate in psychotherapy services.

_____
Print name

_____ _____
Signature of client or responsible party Date

Client's current living situation

_____

If married/partnered, how long have you been together? _____

Spouse/Partner's Name Spouse/Partner's Age

_____ _____

People living in household (please also list any children who are <u>not</u> living in your household):

Name	Age	Gender	Relationship to client
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Client's Occupational Information

<u>Client's Employment Status:</u>

Employed Full-Time ____ Employed Part-Time ____

Unemployed/Other ____ Retired ____

<u>Client's Military/Service Status:</u>

N/A ____ Active Duty ____ Reserves ____

Military Spouse ____ Military Dependent ____

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Student Full-Time ____ Student Part-Time ____

Client's Employer _____ **Employer's Phone** _____

Address _____

City _____ State _____ Zip _____

Highest level of education completed _____

IF CLIENT IS A MINOR: What school does the client attend? _____

What grade is the client in? _____

Emergency Contact Information

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Primary Care Physician _____ **Phone** _____

Psychiatrist _____ **Phone** _____

Other physician(s) relevant to your care (Please list their specialty and name):

_____ **Phone** _____

_____ **Phone** _____

Does Beachside Counseling and Wellness, LLC and/or Virginia Compton, LMHC, have your permission to share your records/minimally necessary health information with the above listed physicians to coordinate care? If yes, please sign:

_____ _____

Client's signature **Date**

_____ _____

Parent/guardian signature (if client is a minor) **Date**

Current Medications (please list all: prescribed, over-the-counter, homeopathic/vitamins/supplements):

Name of medication	Dosage	Frequency	Start date	Prescribing physician

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_____ _____ _____ _____ _____

_____ _____ _____ _____ _____

_____ _____ _____ _____ _____

_____ _____ _____ _____ _____

Hospitalizations: Please list reasons and approximate dates of any hospitalizations

_____

_____

_____

Please list any allergies or medical concerns (including pregnancy):

_____

_____

_____

Current or Past Stressors or Problems with:

____ Occupation/Career	____ Parenting	____ Loss of a Loved One
____ Marriage/Relationship	____ Social Life (Isolation, Conflict, Etc)	____ Physical or Sexual Abuse
____ Legal System	____ Medical/Health Concerns	____ Emotional or Verbal Abuse
____ Finances	____ Chronic Pain	____ Risky Activity

Please mark items in the following list with "Hx" if you have a history of these symptoms, and "PR" if you are presently experiencing them:

____ Anger Problems	____ Crying Spells	____ Change in Appetite
____ Computer Addiction	____ Head Injury	____ Disturbed Body Image
____ Thyroid Problems	____ Unhappiness	____ Memory Problems
____ Dizziness or Fainting	____ Digestive Problems	____ Numbness
____ Seizures	____ Pounding Heart	____ Depression
____ Headaches	____ Muscle Tension	____ Guilt / Shame
____ Migraines	____ Weight Problems	____ Racing Thoughts

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____ Nightmares
____ Trouble falling/staying asleep
____ Heavy drinking
____ Drug Abuse
____ Trouble / Pain Urinating
____ Feelings of inadequacy
____ Cold Hands and Feet
____ Unpleasant Ideas Stay in Head
____ Avoidance
____ Low Energy
____ Excess Energy
____ Panic Attacks
____ Mood Swings
____ Anxiety
____ Chest Pain
____ Purging
____ Hallucinations
____ Loss of Interest in Daily Activities
____ Binge Eating
____ Blackouts
____ Phobia(s)
____ Fatigue
____ Libido Changes
____ Impulsivity
____ Sexual Issues
____ Other

____ Suicidal thoughts – if yes, please state what they sound like, how often they occur, and how long they last:_____

____ Suicide Attempt – if yes, please list date(s): _____

____ Self-harm behavior (including cutting, burning, scratching, head banging)

Developmental and Social Details

Who raised you? Where did you grow up?

_____

Does anyone in your family have a history of mental illness or psychiatric issues? If yes, please list who, their relationship to the client, their diagnosis, and treatment:

_____

Does anyone in your family have any substantial medical conditions or chronic illness? If yes, please list who, their relationship to the client, their diagnosis, and treatment:

_____

What hobbies or activities does the client currently enjoy or would like to explore?

_____

What is your current daily usage of electronics (TV, cell phone, video games, tablet)?

_____

Exercise type and frequency?

_____

Is there anything you would like to share about the client's relational journey (adoption, divorces, LGBTQ, etc)?

_____

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Are you aware of any verbal, physical, emotional or sexual abuse in your family? If yes, please note who/type as you are comfortable:

_____

Has the client ever experienced or witness any verbal, physical, emotional or sexual abuse? If yes, please note who/type as you are comfortable:

_____

Is the client currently still experiencing or witnessing any verbal, physical, emotional or sexual abuse that was previously explained?

_____

Was there anything abnormal about the client's birth (premature, complications, parent used illicit drugs, parent took prescription medication(s), etc)?

_____

Were there any abnormal developmental milestones (delayed walk or speech, potty training struggles, etc)?

_____

Did the client receive any speech, occupational, or physical therapy? If yes, please specify:

_____

Does the client have any special services in school (such as a 504 plan or IEP/Special Education Plan)?

_____

Does the client experience developmental delays in any of the following areas?

____ Speech/Language ____ Occupational/Fine Motor Skills ____ Physical/Gross Motor Skills

____ Vision ____ Hearing

Have you ever been to therapy before? If so, please list approximate dates. IF CLIENT IS A MINOR, are parents/guardians also engaged in their own therapy?

_____

_____

Client's Substance Use History

*****Clients under age 12 – parents/guardians, please use your discretion in collaborating with your child on the completion of the substance use history chart on this page*****

	Ever Used? (Y/N)	Used in Last 3 Months? (Y/N)	Route (smoked, ingested, IV)	Amount and Frequency	Date of Most Recent Use	Prescribed? (Y/N)

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Tobacco						
Alcohol						
Caffeine						
Marijuana/THC						
Amphetamines (Ritalin, Adderall, etc)						
Benzodiazepines (Xanax, Klonopin, etc)						
Opioids (Hydro/Oxycodone, Fentanyl, etc)						

Please list any other substances you have used in your lifetime, and any associated substance use treatment you have engaged in, and associated dates:

_____

_____

ONLY COMPLETE THE FOLLOWING ASSESSMENTS IF YOU ARE 12 YEARS OLD OR OLDER

GENERALIZED ANXIETY DISORDER-7

***Over the last 2 weeks, how often have you been bothered by any of the following problems? Please circle your answers*.**

GAD-7	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

Add the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all Somewhat difficult Very Difficult Extremely Difficult

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PATIENT HEALTH QUESTIONNAIRE-9

Over the last 2 weeks, how often have you been bothered by any of the following problems? Please circle your answers.

PHQ-9	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, like reading the newspaper or watching tv	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed, or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

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Not difficult at all | Somewhat difficult | Very Difficult | Extremely Difficult

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Suicide Risk Screening

For clients ages 12 and older, please complete the following standard suicide/risk assessment questions. Completing this assessment will not initiate a crisis response. This assessment will be used during your first appointment to help facilitate treatment planning and will not be reviewed by the front desk prior to your first visit. If you are currently experiencing thoughts of suicide, you can contact the National Suicide & Crisis Lifeline 24/7 by calling or texting 988. If you are currently having suicidal intent, plan, or method in mind, please immediately call 911 or go to your nearest emergency room.

In the past few weeks, have you wished you were dead? ____Yes ____No

In the past few weeks, have you felt that you or your family would be better off if you were dead? ____Yes ____No

In the past week, have you been having thoughts about killing yourself? ____ Yes ____ No

Have you ever tried to kill yourself? ____ Yes ____ No

Are you having thoughts of killing yourself right now? ____ Yes ____ No

Any other information that might be helpful to your treatment:

_____

_____

_____