S H R E

THERAPY AT THE BEACH

CLIENT INTAKE INFORMATION

Date of first appointment: _____

Please provide the following information. The questions are designed to help me get to know you better so that our time together can be as productive as possible. *If you find the available space for any response to be insufficient, feel free to continue on the reverse side of the form.* Please bring this form with you to your first appointment.

Referred by:

☐ Medical Provider: _____
☐ My website: http://www.shorebeachtherapy.com
☐ Psychology Today
☐ Friend/Family: _____
☐ Other: _____

Educational Level:_____

Relationship Status: _____ Length of current relationship: _____

Have you previously received any type of mental health services?
If yes, when? Please briefly list the reasons.

_____

_____

_____

Please describe the results of treatment or whether it is ongoing. Please include what you found to be most helpful about this treatment and anything you found to be least helpful or unhelpful.

_____

_____

_____

_____

_____

ELIZABETH LABOLT
LICENSED MARRIAGE AND FAMILY THERAPIST

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Have you ever attempted suicide? □ Yes □ No
If yes, when and circumstances that led to the attempt(s)?

_____

_____

Are you presently having suicidal thoughts? □ Yes □ No

Are you currently taking medication for mental health issues? □ Yes □ No
If yes, please list type, dosage, and purpose: _____

_____

_____

Please describe any major losses or traumas you have experienced throughout your lifetime and the approximate age at which you experienced it:

_____

_____

_____

_____

_____

Have you recently experienced any significant life changes or stressful events? If so, please describe them including any of the following: deaths, serious illness, psychiatric disorder, financial crisis/unemployment, divorce, physical/sexual abuse, alcohol/drug abuse, legal problems, eating disorders.

_____

_____

_____

_____

_____

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What is your primary reason or concern for seeking therapy? Please include any specific symptoms you are experiencing and when you first noticed those symptoms.

_____

_____

_____

_____

What would you like to accomplish through therapy? Please include any specific goals you may have:

_____

_____

_____

_____

Physical Health

When was your last complete physical examination? _____

How would you rate your current physical health?
☐ Poor
☐ Unsatisfactory
☐ Satisfactory
☐ Good
☐ Very Good

How would you rate your current sleeping habits?
☐ Poor
☐ Unsatisfactory
☐ Good
☐ Very Good

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If you are having problems, in which phase of sleep are you experiencing issues? Check all that apply.

☐ Falling asleep
☐ Staying asleep
☐ Awakening early
☐ Sleep apnea

Please list any other specific sleep problems you are experiencing:

_____

_____

How many times per week do you generally exercise? _____

What types of exercise do you participate in? _____

_____

Are you currently experiencing any chronic pain? ☐Yes ☐ No

Please list current medications, herbs, or supplements, including the condition for which they have been prescribed.

Medication/Supplement **Dosage** **Condition**

_____

_____

_____

_____

_____

If you would like to provide additional relevant physical health information, please use the reverse side.

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Additional Information

What are the top three stressors in your life?

1) _____

2) _____

3) _____

Are you currently experiencing a predominant emotion? If so, what is it? Are you currently experiencing a full range of emotions? □ Yes □ No Elaborate below:

_____

When you are feeling stressed do you notice any behavioral or physical signs? □ Yes □ No If Yes, please describe:

_____

_____

What is your relationship to your body? Love it? Hate it? Somewhere in between?

_____

If *Fully energized, passionate, and loving my life is a 1*, and *Fried to a crisp is a 10*, Where would you put yourself right now? _____

What are three things that can always make you smile?

1) _____

2) _____

3) _____

What are three things that relax you?

1) _____

2) _____

3) _____

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Do you have any religious or spiritual practices? □ Yes □ No If Yes, what helps you feel more connected to it?

_____

_____

What do you consider to be some of your strengths?

_____

_____

_____

What do you consider to be your biggest challenges?

_____

_____

_____

Can you think of times when your problem(s) is not a problem?

_____

_____

_____

What would your life look like without the problem(s)?

_____

_____

_____

Please provide any additional relevant information you wish to share on reverse side.

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