INTRAPERSONAL WELLNESS

Psychotherapy and Counseling Services

CLIENT INTAKE

Date: ____________________

Name: ____
____

Last First M.I.

Address: _______________________________________ Tel (H) __________
_____ _______________________________________ Tel (C) ____
____

Date of Birth: ________________ Age: _______ Gender: M
F

Referred by: ________________________________How did you hear about us? _____

In case of an emergency, please list who you would like us to notify:

Name ________________________________ Relationship: ____________
____

Address: ____________________________ Phone: ____________________
____________________________ ____________________

Irene C. Lebbad, LCSW • Licensed Clinical Social Worker • Phone: 1.908.963.7645 • Email: irene.lebbad@gmail.com

Listing the emergency contact information above gives us permission to contact those stated in the event of an emergency without prior written consent via Release of Information form.

PLEASE ANSWER THE QUESTIONS BELOW AS ACCURATELY AS POSSIBLE. THIS INFORMATION MAY BE HELPFUL TO THE COUNSELING PROCESS. THANK YOU.

PHYSICAL HISTORY:

1. Please list any medications you are currently taking: ____________
   ____
   ____

2. Please describe any disabilities you may have (i.e. physical, developmental, mental, etc.) ____
   ____

3. Please list any chronic illnesses. ____________________________________
   ____

PSYCHOLOGICAL INFORMATION:

1. Have you ever been diagnosed with a mental illness or other psychological disorders? Yes No

   If yes, please describe: ____

2. Please list any hospitalizations relevant to any mental health issue (i.e. depression, anxiety, suicide attempt, etc.) ____

3. If you are currently seeing a psychiatrist, please provide that information here: ____

4. In the last two weeks, have you thought about harming yourself?

   Yes No

   a. If so, please describe: ____

5. Have you ever intentionally hurt yourself (either currently or in the past)? Yes No

   a. If so, please describe: ____

TRAUMA HISTORY:

1. Have you ever been a victim of or witness to domestic violence?

   Yes No

2. If yes, please briefly describe: ____________________

   ____

   ____

3. Often times, there is a past history of sexual assault or abuse. Please provide a brief history of any types of sexual violence you may have experienced: ____________________

   ____

   ____

4. Please list any other traumas you have experienced (i.e. car accident, accidental death, terrorism, etc.): ____________________

   ____

   ____

SOCIAL/CULTURAL INFORMATION:

1. Please circle the following that best describes your relationship status:

   Married Partnered Single Divorced Separated

   Widowed/Surviving partner

2. Do you have a religious affiliation? Yes No
3. If yes, please describe: ____________________
4. If you reside with others, please provide the information below:

Name	Age	Relationship to you	Supportive? (Y/N)

5. Please list anyone with whom you can count on for support: ______
____
____

6. Please provide information on what you would like to address in counseling: ______________________________________
____
____
____

_______________________________   __________________

Client Signature

Date