Melissa Meuzelaar, MA LPC

Rise & Shine Counseling

Client Intake Form

Name
_____

Name of parent or guardian (if you are a minor)
_____

Birthdate _____/_____/_____

Gender you identify as _____

Marital Status: Never married Partnered Married Separated Divorced Widowed

Number of Children: _____

Local Address:
_____

_____

Preferred Phone: _____May I leave a message? Yes No

Email: _____May I email you? Yes No

**Please be aware that with email, confidentiality cannot be guaranteed. **j

Referred by: _____

Are you currently receiving psychiatric services, professional counseling or psychotherapy elsewhere? Yes No

Have you had previous psychotherapy? Yes No

Previous therapist names

_____

_____

Are you currently taking prescribed psychiatric medication (anti-depressants or others)?

Yes No

If yes, Please list names and dosage:

_____

_____

Health and Social Information

1.How is your physical health at present? Poor Unsatisfactory Satisfactory Good Very Good

Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, arthritis, hypertension, diabetes, asthma, epilepsy, etc..)

_____

_____

_____

Please describe your sleep habits? _____

If any issues with sleep habits, circle where applicable:

Sleeping too little Sleeping too much Poor quality sleep Difficulty Falling asleep

Difficulty waking up Disturbing Dreams

Other_____

How many times per week do you exercise? _____

Approximately how much time? _____

General Perceived effort of exercise: Easy Moderate Hard

Are you having any difficulty with appetite or eating habits? Yes No

If yes, circle where applicable: Eating less Eating More Binging Restricting

Have you experienced significant weight change in last 2 months? Yes No

Do you regularly use alcohol? Yes No If yes, how many drinks per week? _____

How often do you engage in recreational drug use? Daily Weekly Monthly Rarely Never

Are you currently involved in a romantic relationship? Yes No

If yes, how long have you been in this relationship? _____

On a scale of 1-10 (1 being the worst and 10 being the best), how would you rate the quality of this relationship? _____

In the last year, have you experienced any significant life changes or stressors: Please list

_____

_____

On a scale of 1-10 (1 being the worst and 10 being the best), how happy are you with your current friendships? _____

Psychological Information

Have you ever experienced:

Extreme Depressed Mood: No Yes

Wild Mood Swings: No Yes

Panic Attacks: No Yes

Phobias: No Yes

Rapid Speech: No Yes

Sleep Disturbances: No Yes

Extreme Anxiety: No Yes

Hallucinations: No Yes

Unexplained Losses of time: No Yes

Unexplained Memory Lapses No Yes

Alcohol/Substance Abuse: No Yes

Frequent Body Complaints: No Yes

Eating Disorder: No Yes

Negative Body Image: No Yes

Have you had suicidal thoughts recently? Frequently Sometimes Rarely Never

Have you had them in the past? Yes No

Suicide Attempt: No Yes

Homicidal thoughts: No Yes

Occupational Information

Are you currently employed? No Yes

If yes, who is your current employer/position?

_____

If yes, are you happy at your current position?

_____