Refocus Together
Counseling Services

Client Intake Cover Page – Adult

This form is required for your file. The information is needed for claims and/or auditing purposes. Please fill in all areas. **"Client"** refers to person seeking services refer to person seeking services.

Client Full Name: _____

(Circle One) Male Female

Date of Birth: _____ Age ____

Social Security Number: _____

Client Address: _____

Primary Phone Number _____

Do we have permission to text this number? ( ) Yes ( ) No

Do we have permission to leave you a message at this number? ( ) Yes ( ) No

Secondary Phone Number _____

Do We have permission to text this number? ( ) Yes ( ) No

Do we have permission to leave you a message at this number? ( ) Yes ( ) No

Email Address:_____

Martial Status:
Single ( ) Married ( ) Widowed ( ) Separated ( ) Divorced ( )

Please list any
children/age:_____

How did you hear about ReFocus Together? _____

Emergency Contact (Name, Phone, & Relationship): _____
_____

GENERAL HEALTH INFORMATION:

1. Are you currently taking any prescription medication (including psychiatric meds)?

( ) Yes ( ) No

Please list _____

2. How would you rate your current physical health?
3. How would you rate your current sleeping habits?
4. How many times per week do you generally exercise? _____
5. Please list any difficulties you experience with your appetite or eating patterns_____

MENTAL HEALTH INFORMATION:

6. Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

( ) Yes ( ) No
If yes, previous therapist/physician:_____

Have you ever been prescribed psychiatric medications?

( ) Yes ( ) No

If yes, please list and provide dates:_____

_____

7. Are you experiencing overwhelming sadness, grief, or depression?

( ) Yes ( ) No

If yes, for how long? _____

8. Are you experiencing anxiety, panic attacks, or any phobias?

( ) Yes ( ) No

If yes, when did this start? _____

9. Are you experiencing chronic pain?

( ) Yes ( ) No

If yes, please describe _____

10. Do you drink alcohol more than once a week?

( ) Yes ( ) No

11. How often do you engage in recreational drug use (marijuana, CBD, etc…)?
_____

12. Are you currently in a romantic relationship?

( ) Yes ( ) No

If yes, for how long? _____

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

13. Have you experienced any childhood trauma (molestation, abuse, death of a loved one, etc.) ?

( ) Yes ( ) No

If yes, please explain_____

_____

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

_____

FAMILY MENTAL HEALTH HISTORY:

In this section below identify if there is a family history of any of the following.

Alcohol/Substance Abuse ( ) Yes ( ) No

Anxiety ( ) Yes ( ) No

Depression ( ) Yes ( ) No

Domestic Violence ( ) Yes ( ) No

Eating Disorders ( ) Yes ( ) No

Obesity ( ) Yes ( ) No

Obsessive Compulsive Behavior ( ) Yes ( ) No

Schizophrenia ( ) Yes ( ) No

Suicide or Attempts ( ) Yes ( ) No

ADDITIONAL INFORMATION:

Sessions Fees and Copays: Due at the beginning of each appointment. Payments may be made by credit card, checks, or cash.

1. Are you currently employed? ( ) Yes ( ) No

If yes, what field do you work in? Your position?

_____

Do you enjoy your work? Is there anything stressful about your work?

_____

_____

2. Do you consider yourself to be spiritual or religious? ( ) Yes ( ) No

If yes, describe your belief:

_____

3. What do you consider to be some of your strengths? _____

_____

4. What do you consider to be some of your weaknesses?_____

_____

5. What would you like to accomplish out of your time in therapy? _____

_____

Checks should be made payable to **ReFocus Together Counseling Services, LLC.**

_____

Printed Name of the Client Date

_____

Signature of the Client/Guardian Date