# Juniper Campbell, LPC

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## Individual Day Intensive Intake Form

### GENERAL INFORMATION

Patient Name:_____ Date of Birth:__/__/__ Age:____
Gender: [ ] Male [ ] Female
Home Address:_____
City_____ State_____ Zip Code_____

Home Phone Number:_____ May I leave a message? [ ] Yes [ ] No
Work Phone Number:_____ May I leave a message? [ ] Yes [ ] No
Cell Number:_____ May I leave a message? [ ] Yes [ ] No

**Emergency Contact:**
Name of contact:_____
Relation to patient:_____
Phone number:_____

### INTERPERSONAL HISTORY

Marital Status: [ ] Single [ ] Married [ ] Separated [ ]Divorced [ ] Widowed [ ] Other
Children (Please list name, age and sex):
_____
_____

Were you raised by: [ ] Both parents? [ ] Single parent? [ ] Relative? [ ] Adopted? [ ] Other?

In your family is there a history of: [ ] Alcoholism [ ] Drug Addiction [ ] Mental Illness [ ] Prolonged physical illness_____

Do you have a good support system: [ ] Yes [ ] No

### MEDICAL/MENTAL HEALTH HISTORY

Current Medications and Dosages:
_____
_____
_____

Do you have any significant medical problems:
_____
_____

Did you meet all of your developmental milestones: [ ] Yes [ ] No

Have you had previous psychiatric care and/or counseling: [ ] Yes [ ] No
Name of Clinician:_____
Sessions from: _____to_____
Have you ever received a formal mental diagnosis: [ ] Yes [ ] No
If yes, please provide
diagnosis:_____

Have you ever been hospitalized for issues related to your mental health [ ] Yes [ ] No
If yes, when, where and for what reason:
_____
_____
_____

Do you have a trauma history (physical, sexual, emotional) [ ] Yes [ ] No
If Yes, please give a brief description of the nature of the trauma, who was involved and when it occurred:
_____
_____
_____

Do you have a history of self-harming [ ] Yes [ ] No

Is there a history of any suicide attempts? If yes, please elaborate [ ] Yes [ ] No
_____
_____

Are you currently suicidal [ ] Yes [ ] No

**OCCUPATION/EDUCATION/MILITARY**

Level of Education:_____
Current Employment:_____

Are you a veteran?: [ ] Yes [ ] No
If yes, Branch of military:_____
Rank:_____
What jobs did you have in the military:_____
_____
What dates and where did you serve:_____
_____

Did you see combat [ ] Yes [ ] No
Enemy Fire [ ] Yes [ ] No
Casualties [ ] Yes [ ] No

Do you have family members that served in the military

_____

**LEGAL INFORMATION**

Are there any present or past legal issues (arrest history, DUI, incarceration, litigation)?_____

_____

**LIFESTYLE INFORMATION**

How many times a week do you exercise and what type of exercise do you prefer:

_____

_____

Describe your eating habits (do you eat three meals a day, vegetables, fruits, meat, snacks, late night eating...):

_____

_____

What junk food do you love to eat (soda, chocolate, chips...) and how often do you eat these foods:_____

_____

What supplements do you take:

_____

_____

If you drink alcohol, what are your drinking habits: [ ] rarely drink [ ] 1-3 times per week [ ] 3-5 times per week[ ] everyday [ ] don't intend to drink as much as I do sometimes [ ] black out when drinking [ ] drink to get drunk

How much sleep do you get: [ ] 3-5 hrs. per night [ ] 5-7 hrs. per night [ ] 7-9 hrs. per night [ ] 9-12 hrs. per night?

How much television do you watch: [ ] none [ ] 1-2 hrs. a day [ ] 2-4 hrs. a day [ ] 4-6 hrs. a day [ ] 6+ hrs. a day

How much time do you spend playing video games: [ ] none [ ] 1-2 hrs. a day [ ] 3+ hours a day

How much time do you spend on social media: [ ] none [ ] 1-2 hrs. a day [ ] 3+ hours a day

How do you sabotage yourself and your goals?

_____

_____

_____

**PERSONAL AND THERAPEUTIC GOALS**

What are 3 goals that you would like to work towards in therapy:
1. _____
2. _____
3. _____

Name 3 of your strengths:
1. _____
2. _____
3. _____