Juniper Campbell, LPC

Individual Session 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:_____

What brings you to therapy at this time? Is there something specific, such as a particular event?

_____
_____
_____
_____
_____

When did this problem first appear?

_____

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 sound support system: [ ] Yes [ ] No

Describe your current living situation. Do you live alone, with others, with family, etc.? Do you feel safe and comfortable in your home? Does your housing meet your needs, or is it lacking somehow? Is your home a stressful or relaxing environment?

_____
_____
_____
_____

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:_____

What do you think about the diagnosis (i.e., Did you agree with it? Did you feel better or worse after the diagnosis?

_____
_____
_____

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

_____
_____
_____

Have you been diagnosed as any of the following – Borderline Personality Disorder, Major Depressive Disorder, Bipolar Disorder Type I, Severely Mentally Ill, Schizophrenia, or Chemically Addicted?

_____
_____

Have you ever had a concussion or head injury where you lost consciousness or been diagnosed with a Traumatic Brain Injury? [ ] Yes [ ] No

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:
_____
_____
_____

Have you ever had an experience that you would consider traumatic that does not involve physical, sexual, or emotional abuse? If Yes, please give a brief description of the nature of the trauma:_____
_____
_____

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

Do you have thoughts of harming others [ ] Yes [ ] No

OCCUPATION/EDUCATION/MILITARY

Level of Education:_____
Current Employment:_____

Are you a veteran?: [ ] Yes [ ] No
If yes, Branch of military:_____
Rank at time of discharge:_____

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 [ ] blackout 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 three goals that you would like to work towards in therapy:
1. _____
2. _____
3. _____

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