South Charlotte Counseling and Psychotherapy, PLLC

Jumana S Scoggins, MA, NCC, LPC

CLIENT INTAKE FORM

Please provide the following information for our records. This information will remain confidential. Please print out this form and bring it to your first session.

Name: _____
(Last) (First) (Middle Initial)

Name of parent/guardian (if you are a minor):

_____
(Last) (First) (Middle Initial)

Birth Date: _____ /_____ /_____ Age: _____ Gender: □ Male □ Female

Marital Status:

□ Never Married □ Partnered □ Married □ Separated □ Divorced □ Widowed

Address: _____

Home Phone: ( ) _____ May we leave a message? □ Yes □ No

Cell/Other Phone: ( ) _____ May we leave a message? □ Yes □ No

E-mail: _____ May we email you? □ Yes □ No
*Please be aware that email might not be confidential.

Emergency Contact: _____ Phone : ( ) _____

Referred By: _____

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

Have you had previous psychotherapy? □No □Yes

Previous therapist's name _____

Are you currently under a physician's care? □ Yes □ No

List of current medications (prescription and non-prescription):

HEALTH AND SOCIAL INFORMATION

1. How is your physical health at present? (please circle)

Poor Satisfactory Good Excellent

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

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3. Are you having any problems with your sleep habits? □ N □ Y
If yes, check where applicable:

□ Sleeping too little □ Sleeping too much □ Poor quality sleep □ Disturbing dreams
□ Other _____

4. How many times per week do you exercise? _____

5. Are you having any changes in appetite or eating habits? □ N □ Y

Have you experienced significant weight change in the last 2 months? □ N □ Y

6. Do you regularly use alcohol? □ N □ Y

How much? _____

7. Do you use drugs? □ N □ Y

8. Have you had suicidal thoughts recently? □ Frequently □ Sometimes □ Rarely
□ Never

Have you had them in the past? □ Frequently □ Sometimes □ Rarely □ Never

9. Are you currently in a romantic relationship? □ N □ Y
If yes, how long have you been in this relationship? _____

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

10. In the last year, have you experienced any significant life changes or stressors:

Have you ever experienced:

Extreme depressed mood: □ N □ Y

Wild Mood Swings: □ N □ Y

Rapid Speech: □ N □ Y

Extreme Anxiety: □ N □ Y

Panic Attacks: □ N □ Y

Phobias: □ N □ Y

Hallucinations: □ N □ Y

Alcohol/Substance Abuse: □ N □ Y

Eating Disorder: □ N □ Y

Body Image Problems: □ N □ Y

Repetitive Thoughts (e.g., Obsessions) : □ N □ Y

Repetitive Behaviors (e.g., Frequent Checking, Hand-Washing) : □ N □ Y

Homicidal Thoughts: □ N □ Y

Suicide Attempt: □ N □ Y

OCCUPATIONAL INFORMATION:
Are you currently employed? □ N □ Y

If yes, who is your current employer/position?
_____

If yes, are you happy at your current position?
_____

Please list any work-related stressors, if any:
_____

RELIGIOUS/SPIRITUAL INFORMATION:

Do you consider yourself to be religious? □ N □ Y
If yes, what is your faith?
_____

If no, do you consider yourself to be spiritual? □ N □ Y

COORDINATION OF CARE:

It is important that all health care providers work together. As such, we would like your permission to communicate with your primary care physician and/or psychiatrist/previous therapist. Your consent is valid for one year. Please understand that you have the right to revoke this authorization, in writing, at any time by sending notice. However, a revocation is not valid to the extent that we have acted in reliance on such authorization. If you prefer to decline consent no information will be shared.

_____ I approve the coordination of care with my physician/clinician

_____ I decline to have my care coordinated with my physician/clinician

Physician/Clinician Name: _____

Address: _____

Phone:_____

Signature : _____ Date_____