Julie Larson, LCSW
www.julielarsonlcsw.com

CLIENT INTAKE FORM

**All information provided here is protected as confidential information.*

Name: _____
(LAST) (FIRST)

Date of Birth: _____ Age: _____

Address: _____
(STREET)

_____
(CITY, STATE) (ZIP)

Primary Phone #: _____ Ok to leave message ☐

Secondary Phone #: _____ Ok to leave message ☐

E-mail Address: _____ Ok to email ☐
(Please be aware that email might not be confidential)

Preferred Method of Contact: ☐ Phone ☐ Email

Have you ever received any type of mental health services (psychotherapy, psychiatric services, psychiatry, etc) in the past? ☐ YES ☐ NO

If so, how was that experience for you?
1 2 3 4 5 6 7 8 9 10
(not helpful) (very helpful)

Are you currently taking any prescription medication? ☐ YES ☐ NO

Please list: _____

Have you ever been prescribed psychiatric medication? ☐ YES ☐ NO

Please list with dates: _____

Referred By: _____

EMERGENCY CONTACT: Name: _____

Relationship: _____ Phone #: _____

INSURANCE INFORMATION:
Insurance: _____ ID Number: _____

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GENERAL HEALTH AND MENTAL HEALTH INFORMATION

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1. How would you rate your current physical health?
☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very Good

Please list any specific health issues you are currently experiencing:

_____

2. How would you rate your current sleep habits?
☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very Good

Please list any specific sleep related issues you are currently experiencing:

_____

3. Have you experienced any recent changes (or concerns) with regard to your level of activity, appetite or eating patterns? ☐ YES ☐ NO

Please explain: _____

4. Are you experiencing overwhelming sadness, grief or depression?
☐ YES ☐ NO

If yes, how long? _____

5. Are you experiencing anxiety or panic attacks? ☐ YES ☐ NO

If yes, when did you begin experiencing these feelings? _____

6. Are you currently experiencing any chronic pain? ☐ YES ☐ NO

if yes, please describe: _____

7. Are you originally from the New York City area? ☐ YES ☐ NO

If no, where would you say your are from: _____

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

_____