JULIA WALL, M.ED., L.P.C.

INTAKE FORM

Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information,

Please fill out this form and bring it to your first session.

Name:_____
Last First Middle Initial

Name of parent/guardian (if under 18 years): _____
Last First Middle Initial

Birth Date: _____/_____/_____ Age: _____ Gender: _____

Marital Status:
☐ Never Married ☐ Domestic Partnership ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Please list any children/age: _____

Address: _____
Street & Number

_____
City State Zip

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

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

Email: _____ May we email you? ☐ Yes ☐ No
*Please note: Email correspondence is not considered to be a confidential medium of communication.

How did you hear about us?: ☐ Google Search ☐ Insurance Referral ☐ Website ☐ Referred by: _____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?
☐ No ☐ Yes, previous therapist/practitioner: _____

Have you ever been hospitalized for mental health services? ☐ No ☐ Yes
If Yes, what hospital? _____, How long? _____

Are you currently taking any prescription medication? ☐ No ☐ Yes
Please list:_____
_____

Client Signature: _____ Date: _____

734 E. Corsicana Street
Suite B
Athens, TX 75751
Ph. 936-727-0393

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health? (please circle)
Poor Unsatisfactory Satisfactory Good Very Good

Please list any specific health problems you are currently experiencing:
_____
_____

2. How would you rate your current sleeping habits? (please circle)
Poor Unsatisfactory Satisfactory Good Very Good

Please list any specific sleep problems you are currently experiencing:
_____
_____
_____

3. Are you currently experiencing overwhelming sadness, grief or depression? □ No □ Yes
If yes, for approximately how long? _____

4. Are you currently experiencing anxiety, panic attacks or have any phobias? □ No □ Yes
If yes, when did you begin experiencing this? _____

5. Are you currently experiencing any chronic pain? □ No □ Yes
If yes, please describe:_____

6. Do you drink alcohol more than once a week? □ No □ Yes

7. How often do you engage recreational drug use? □ Daily □ Weekly □ Monthly □ Infrequently □ Never

8. What significant life changes or stressful events have you experienced recently:

FAMILY MENTAL HEALTH HISTORY:

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

	Please Circle	List Family Member
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	

Client Signature: _____ Date: _____

ADDITIONAL INFORMATION:

1. Are you currently employed? ☐ No ☐ Yes
If yes, what is your current employment situation: _____

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

_____
_____
_____

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

_____
_____
_____
_____
_____

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

_____
_____
_____
_____

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

_____
_____
_____
_____
_____
_____
_____
_____
_____

Client Signature: _____ Date: _____

SELF HARM ASSESSMENT

Have you ever:

- Had thoughts of harming yourself or suicidal thoughts ☐ Yes ☐ No
- Attempted Suicide ☐ Yes ☐ No
  If yes, how many times? _____
  What method did you use? _____
- Used cutting yourself for anger release ☐ Yes ☐ No
  If yes, how often? _____
  Where did you cut? _____

If you answered yes to any of the above questions, what were the precipitating factors that led you to that decision?

_____
_____
_____

Are you currently:

- Having thoughts of harming yourself or suicide ☐ Yes ☐ No
  If yes, how often? _____
  What method would you use? _____
- Using cutting yourself for anger release ☐ Yes ☐ No
  If yes, how often? _____
  Where do you cut? _____

If you answered yes to any of the above questions, what were the precipitating factors that led you to that decision?

_____
_____
_____

Has anyone in your family:

- Ever attempted or completed a suicide attempt ☐ Yes ☐ No
  If yes, who and how? _____

Client Signature: _____ Date: _____

Name: _____ Date: _____

SUBSTANCE ABUSE HISTORY

Do you drink alcohol? Yes/No

If so, how much: _____

How often: _____

Do you smoke? Yes/No

If so, how much: _____

How often: _____

Do you "use" prescription drugs? Yes/No

___ Valium ___ Xanax ___ Oxycotin
___ Codeine ___ Ritalin ___ Adderol
___ Prozac ___ Other: _____

If so, how much: _____

How often: _____

What other drugs have you tried?

___ marijuana/"pot"/"weed" ___ cocaine ___ Heroine
___ Ecstasy ___ Acid ___ Crack
___ GHB ___ Huffing ___ Bath Salts
___ Skittles ___ Other: _____

Have you ever been hospitalized for substance abuse? Yes/No

If so, when:_____

Where?_____

How long?_____

Are you currently using drugs/alcohol? Yes/No

If so, what?_____

Are you currently in substance abuse treatment? Yes/No

If so, where?_____

Client Signature: _____ Date: _____

CURRENT ISSUES

Reason for today's visit:

_____
_____
_____
_____

Circle the words that best describe yourself.

Depressed	Mad	Unlovable
Happy	Heavy	Neglected
Tearful	Lost	Used
Angry	Grateful	Abused
Sad	Concerned	Nervous
Lonely	Afraid	Melancholy
Frustrated	Anxious	Excited
Loving	Loved	Worthless
Worthy	Friendly	Friendless
Invincible	Hostile	Irritable
Grouchy	Ecstatic	Gifted
Stressed	Bored	Restless
Hurt	Relaxed	Satisfied

Areas of concern for me are:

___ Marriage	___ Health	___ Financial
___ Children	___ Friends	___ Relationships (male/female)
___ Substance abuse	___ Parents	___ Physical/sexual abuse
___ In-laws	___ Work	___Other: _____
		_____
		_____

I, _____, verify the above information is true. I understand the above information will be kept confidential and used only for the purpose of diagnosis and treatment.

Client Signature: _____ Date: _____

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