700 Alhambra Blvd. Lower Floor ■ Sacramento, CA 95816

**Client Intake Form**

NAME: _____ DATE: _____

ADDRESS: _____

CITY _____ ZIP_____

SSN: _____ DOB: _____

Referred by: _____

Place of Employment/Position: _____

Phone Numbers: (H) _____

(C) _____

Number of Children: _____ Ages: _____

Names of people in your Household:

_____

_____

We would love to keep you in the loop. We send out 1-2 emails per month with a newsletter, an art activity, and recommendations on community resources. Would you like to opt-in to that email list? Your information will be kept private and secure. We will not sell your information.
(  )Yes (  )No  E-mail address: _____

Please describe your reasons/goals for requesting services (be specific, if possible):

_____

_____

_____

_____

_____

_____

_____

**Mental Health History**

Which of the following kinds of psychological/psychiatric services have you received prior to coming here? PLEASE CHECK ALL THAT APPLY.

( ) None ( ) Partial care ( ) Other 24-hour care
( ) Outpatient therapy ( ) Inpatient care

How many times have you received psychological/psychiatric services prior to coming here?

( ) None ( ) 3 – 4
( ) 1 – 2 ( ) 5 or more, but fewer than 10 ( ) 10 or more

Have you experienced any of the following problems?
PLEASE CHECK ALL THAT APPLY.

( ) Anxiety
( ) Depression
( ) Extreme mood swings
( ) Alcohol or drug abuse
( ) Unusual thought or beliefs
( ) Learning disability
( ) Self-inflicted pain or injury
( ) Social isolation
( ) No appetite
( ) Always tired
( ) Unable to relax
( ) Recurrent dreams
( ) Hallucinations
( ) Feel tense
( ) Fears and phobias
( ) Suicidal ideas
( ) Can't make friends
( ) Poor living conditions
( ) Always worried about something
( ) Can't make decisions
( ) Financial problems
( ) Job problems
( ) Other _____
( ) Victim of abuse
( ) Eating disorder
( ) Criminal behavior/incarceration
( ) Aggression/violence
( ) Overwhelming crisis
( ) Recurrent conflicts with others
( ) Sexual problems
( ) Other mental health problem
( ) Over-eating
( ) Always sleepy
( ) Insomnia
( ) Nightmares
( ) Inferiority feelings
( ) Feel panicky
( ) Obsessions
( ) Shy with people
( ) Afraid of people
( ) Unable to have a good time
( ) Don't like weekends/vacations
( ) Over-ambitious
( ) Gambling
( ) Can't keep a job

If you have ever attempted suicide, <u>when</u> did your <u>most recent</u> attempt occur?

( ) I have never attempted suicide
( ) Within the last month
( ) More than 1 month ago, but within the last year
( ) More than 1 year ago, but less than 5 years ago
( ) More than 5 years ago

**Medical History**

How many serious injuries (that needed medical attention) have you had?

_____

_____

How many surgeries have you had? _____

Please list current drugs or medications, average dose, and frequency:

_____

_____

Who is currently monitoring your medication (if any) for psychological problems?

_____

If there are any other medical or physical problems, which you feel might be important to my ability to be of help to you, please explain here:

_____

_____

Who is your current physician? _____

In the event of an emergency (you fall, hurt yourself, etc.), who would you like us to contact?

_____