VALENTINO THERAPY CLIENT INTAKE INFORMATION FORM

Client Name: (please print) _____ Date: _____

Address: _____City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ DOB: _____

Employment or School: _____ Address: _____

Job Title or Course of Study_____ Time on Job or in School: _____

Referral Source, website, search engine, or other: _____

Emergency Contact: (name) _____ Relationship _____ Phone:_____

IF YOU NEED MORE ROOM, WRITE ON THE BACK OR ATTACH EXTRA PAGES.

Reason for Treatment, Help or Support at this time:

Describe the overall impact these concerns and issues have had on your life, including any changes or consequences which may have resulted:

What are you most concerned will happen if your concerns or issues continue?

Have you had Psychotherapy or other types of treatment before? (With whom, how long, outcome?)

Have you ever been diagnosed with an acute or chronic psychiatric disorder? If so, have you ever sought treatment? Psychotherapy? Medications? Hospitalizations? Outcome?

Does anyone in your family have a history of psychiatric problems or difficulties you want to inform me of?

Do you have any current or past compulsive or addictive behaviors, or behaviors that are troublesome to you or those close to you?

What is your sexual orientation (answer is optional): Heterosexual Bisexual Homosexual
Are you currently in a relationship? No Yes

Please describe your relationship and the quality of it:

Will your relationship impact the quality or outcome of your therapy?

Has your relationship history been positive (please explain)?

What is your relationship history with your parents or the persons who raised you (please explain)?

How would you describe your level of motivation and willingness to overcome what brought you to therapy?

What do you hope to accomplish in therapy?

What do you know of therapy/clinical hypnosis and do you have preferences of theories, types of work we do?

What role, if any, does spirituality will play in your life, behavior and future and/or your therapy?

Do you suffer from PTSD or Stress Disorders? If so, please explain.

Do you suffer from Anxiety Disorders? If so, please explain.

Do you suffer from Depressive Disorders? If so, please explain.

Do you suffer from Sleep Disorders? If so, please explain.

Physical Health: Do you currently have physical diagnoses or problems?

If you are taking any medications, please list their names, dosage, how often you take them and who prescribed each one:

Please list your medical or psychiatric physicians and any other medical or treatment professionals you are currently seeing or under treatment with, their names and phone numbers:

Have you ever intentionally injured yourself in any way (please explain in detail)?

Have you ever contemplated or attempted suicide? If so, are you having any such thoughts now?

Have you ever contemplated or attempted injuring others? If so, are you having any such thoughts now?

Have you ever been the victim of sexual, emotional or physical abuse (please explain when and by whom)?

Have you ever been accused of sexual or physical abuse (let's discuss details in session)?

What do you find particularly troubling and annoying in yourself or others?

What pleases you?

When do you feel safe and happy or content?

When do you feel unsafe, angry or troubled? Do you know your triggers?

What forms of self-soothing do you use? How do you calm down or make yourself feel better?

When do you feel unsafe, angry or troubled? Do you know your triggers?

What substances do you use and how often? Do you ever think you use too much? Do those closest to you?

Have you ever sought treatment for substance problems; if so please explain in detail?

Is there any other information you would like to add to this assessment?