Rev. Santa CanteWi Molina-Marshall – licsw, sep

1025 Connecticut Avenue NW, Suite 1000, 10th Floor,

Washington DC, 20036

www.hpbysanta.net . hpbysanta@gmail.com . 301537-6091

Client Psychotherapy Intake Forms

Date: ____________________

Name: ____

Address: ____

Telephone No.: (H/C) ______________________________ (W) _________________________________

Email: ____

Gender _____________ Race ________________ Sexual Orientation_______________________________

Age: _____ Date of Birth _____________________ Place of Birth ___________________________

Check as many as apply:	Committed Relationship _____ Divorced _____	Single _____ Separated _____

Highest level of education attained: ____

Place of Employment: (Tenure & Title) ____

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

____

____

____

Name of child/children:	Age:	Date of birth:
_____________________________	____________	_____________________________
_____________________________	____________	_____________________________
_____________________________	____________	_____________________________
_____________________________	____________	_____________________________

Do you consider yourself to be spiritual or religious, if yes, describe your faith or belief.

____

____

____

Have you ever been involved in therapy or any other type of counseling program? ☐Yes ☐No

If yes, when? ____________________ Where? ____

Reasons: ____

Reasons for considering counseling at this time: ____

____

____

____

Were you referred to this counseling office? ☐Yes ☐No If yes, by whom? __________________________

Are you in treatment with another counselor presently? ☐Yes ☐No

If yes, with whom? Name: ____________________________How long? __________________________

Have you ever been hospitalized for any mental health reason? ☐Yes ☐No

If yes, when? ______________________________ Where? ______________________________________

Reason: ____

Are you receiving medical treatment from a psychiatrist? ☐Yes ☐No

If yes, with whom? Name: __________________________________ Phone _______________________

(Please be sure to complete and bring in in with you the consent form you will find under "helpful forms" on the website).

How would you rate your current physical health? (Please circle one)

Poor Unsatisfactory Satisfactory Good Very Good

Please list any specific health problems you are currently experiencing:

____

____

Are you presently under a physicians care for physical problems? ☐Yes ☐No

If yes, please list reasons and any medications: ____

____

Name of family physician: ______________________________ Phone: _____________________________

How would you rate your sleeping habits? (Please circle one)

Poor Unsatisfactory Satisfactory Good Very Good

Please list the specific problems you are having, if any ____-
____

How many times per week do you exercise ____

List any difficulties you experience with your appetite or eating patterns: ____________________________
____
____

Are you currently experiencing overwhelming sadness, grief or depression? If yes, describe and include for how long?____
____
____

Are you currently experiencing anxiety, panic attacks or have any phobias? If yes, describe and include when you began to experience this. ____
____
____
____

Are you currently experiencing any chronic pain? If yes, describe_____________________________________
____
____

Do you struggle with any type of addiction (this includes food, alcohol, illegal drugs, prescription drugs, gambling and or sex) If so, please explain. ____
____
____
____

How frequently do you use these substances or engage in addictive behaviors? ________________________
____

Have you ever, or are you now being treated by any type addiction. ☐Yes ☐No

If yes, when? ____________________ Where? ____

By whom? ______________________ Length of treatment _____________________________________

Have you experienced any form of trauma? (please include a listing of your experiences. Include, major falls, accidents, major surgeries, childhood or adult sexual abuse, neglect, physical/emotional abuse, and any other experiences you consider traumatic). Specifics are not expected. We can discuss these in person iin a regulated way.

____
____
____
____
____
____

Are you currently in a relationship? If so, for how long and how would you rate it on a scale of 1-10_______
How supportive is your partner/spouse? ____
____
____

Describe intimacy relationship history, starting with the present.

____
____
____

What do you consider to be some of your weaknesses?

____
____
____

What do you consider to be some of your strengths?

____
____
____

What concerns/challenges are you experiencing at this time?

____
____
____

What would you like to accomplish from your time in therapy?

____

____

____

What resources do you have (internal and external) that help you feel a bit better?

____

____

____

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
Alcohol/Substance Abuse	YES/NO	
Other addictions	YES/NO	
Depression	YES/NO	
Domestic Violence	YES/NO	
Eating Disorders	YES/NO	
Obesity	YES/NO	
Obsessive Compulsive Behavior	YES/NO	
Schizophrenia	YES/NO	
Suicide/Suicide Attempts	YES/NO	
Narcissistic Personality	YES/NO	

Please use this page to list any other information you deem important to share with me, that was not asked above.

____
____
____
____
____
____
____
____
____
____
____
____
____

Person to contact in case of an emergency: ____

Phone: _______________ Email:______________________ Relationship to you:____________

Address: ____

____

________________________________ Date:_________________________

(Your Signature)

Thank you for taking the time to complete this form. This will help me to serve you.