ReflectionTherapy

## REGISTRATION AND INTAKE FORM

*Thank you for choosing Reflection Therapy to assist you with your therapeutic needs.*
*Please complete the intake form information as best you can.*

## PERSONAL & FAMILY MEMBER INFORMATION

Client Name _____ Spouse/Partner _____

Date of Birth _____ Date of Birth _____

Employer _____ Employer _____

Address _____ City _____ Zip _____

Mobile: _____ Land Line _____ Other Phone: _____

May we leave a message? **Mobile**: ☐ Yes ☐ No; **Land Line**: ☐ Yes ☐ No; **Other Phone**: ☐ Yes ☐ No

***Children/Household Members***

| Name | Date of birth | Relationship to you |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

## REFERRAL INFORMATION

How did you find out about Refection Therapy Services?

***Check appropriate box:***

- □ Friend(s)/Neighbors
- □ Family Member
- □ Physician/Family Doctor
- □ Internet
- □ Social Service Agency
- □ Court System
- □ School System
- □ Mental Health Center
- □ Other (please specify) _____

May we send a thank-you note to this referring source? ☐ Yes ☐ No
If yes, where should this be sent?

_____

## PREVIOUS THERAPY EXPERIENCE

Have any of the family members listed on this form received mental health services (counseling/therapy) in the past?
☐ Yes ☐ No

If YES . . .
Which family members? _____

When? _____ Where or with whom? _____

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## PREVIOUS THERAPY EXPERIENCE, cont.

For what reason? _____

_____

_____

What was *most* helpful about your previous therapy experience?

_____

_____

_____

_____

What was *least* helpful about your previous therapy experience?

_____

_____

_____

_____

## PHYSICIAN CONTACT HISTORY

**Primary Care Physician**: _____ Phone Number: _____

Are you currently under the care of a psychiatrist? ☐ Yes ☐ No
If YES, who are you seeing?

**Psychiatrist**: _____ Phone Number: _____

## PSYCHOTROPIC MEDICATION HISTORY

| |
|---|
| Name of person taking medication:<br>Medications:<br><br>Reason for taking: |
| Name of person taking medication:<br>Medications:<br><br>Reason for taking: |
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Have you ever been hospitalized for reasons relevant to therapy? If YES, please describe:

Briefly describe what brings you to therapy at this time:

What would you like to see happen as a result of therapy?

Is a religious or faith perspective important to you in therapy? ☐ Yes ☐ No

In what ways?

*Thank you for providing the information requested on this form. This information is considered confidential and will not be shared with anyone other than your therapist unless permission is granted through written consent.*