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 _____ Age _____ 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

Email Address: _____

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

PHYSICIAN CONTACT HISTORY

Primary Care Physician: _____

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

Psychiatrist: _____

PSYCHOTROPIC MEDICATION HISTORY

Name of person taking medication: Medications: Reason for taking:
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PREVIOUS THERAPY EXPERIENCE

Have YOU ever received mental health services (counseling/therapy) in the past?
☐ Yes ☐ No
If YES . . .

When? _____

Where? _____

With whom? _____

For what reason?

_____

_____

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

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

Have YOU ever been hospitalized for reasons relevant to therapy? If YES, please describe:

Briefly describe what brings you to therapy now:

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?

Do you . . .

Consume alcohol? ☐ Yes ☐ No
If YES, how much each week?

Use marijuana? ☐ Yes ☐ No
If YES, how much each week?

Have any of IMMEDIATE FAMILY MEMBERS listed on this form received mental health services (counseling/therapy) in the past?

☐ Yes ☐ No

If YES . . .
Which family members?_____

When? _____

Where? _____

With whom? _____

For what reason? _____
_____
_____

ALL INFORMATION ON THIS FORM IS CONSIDERED CONFIDENTIAL AND WILL NOT BE SHARED <u>WITH ANYONE</u> OTHER THAN YOUR THERAPIST UNLESS PERMISSION IS GRANTED THROUGH WRITTEN CONSENT.