GROWTH AND GRATITUDE, PLLC

Online Therapy

Updated September 2023
Growth and Gratitude, PLLC
Dr. Dan Sneider-Cotter, LCSW, Ed.D
53 Onteora Blvd. Asheville, NC 28803
NORTH CAROLINA: CO13376
FLORIDA LICENSE: SW15740
COLORADO LICENSE: CSW.09923224
ILLINOIS LICENSE: 149015355

Name: ___________________________________

Date of Birth: ______________________________

Client Intake Form

Please take your time in providing the following information. The questions are designed to help begin to understand you so that session time can be as productive as possible. All information provided is confidential.

Referred by: ____

Website: growthandgratitudetherapy.com: ____ PsychologyToday: ____

Friend/Family: ____ Medical Provider: ____

Have you previously received any type of mental health services?

Yes: ____ No: ____

If yes, which of the following:

Psychotherapy: ____ Medication: ____

Outpatient Hospitalizations: ____ Inpatient Hospitalization: ____

If yes, please provide:

Name of provider or facility:____

Location:____

Dates of treatment:____

Reason for treatment:____

Briefly, what brings you in today?

When did your problem first start? Within the last:

30 days: ___

6--12 months: ___

More than 1 year ago: ___

During adolescence: ___

During childhood: ___

Are you currently experiencing overwhelming sadness, grief or depression?

Yes: ___ No: ___

If yes, for approximately how long? ______________________

When is the last time you had a plan for Suicide?

Never: ___ 30 days: ___

6--12 months: ___ More than 1 year ago: ___

During adolescence: ___ During childhood: ___

During the past 7 days - Please stop what you are doing and contact the National Suicide Prevention Lifeline at 988 for immediate support and consultation so that you can create a safety plan with services in your area

Are you currently experiencing anxiety, panic attacks or have any phobias?

Yes: ______ No: _____

If yes, when did you begin experiencing this? __________________________________

Please describe any major losses or traumas that would be helpful for the Therapist to know (this can also be discussed during initial session):

What significant life changes or stressful events have you experienced recently?

What would you like to accomplish out of your time in therapy?

Family 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.). Alcohol/Substance Abuse: ____

Anxiety: ____

Depression: ____

Domestic Violence: ____

Sexual Abuse: ____

Eating Disorders: ____

Obsessive Compulsive Disorder: _____________________________________

Schizophrenia: ____

Suicide Attempts: ____

Other diagnosed mental health conditions?: ___________________________

Physical Health

Please list any medications, herbs, or supplements. Be sure to include the condition, as some medications are prescribed for off-label use.

Medication/Supplement	Dosage	Condition for Treatment	Date Began/Stopped

Prescribing provider and contact information:

Name: ____

Phone/Email: ____

How would you rate your current physical health?

Poor: ______________________

Unsatisfactory: ______________

Satisfactory: ________________

Good: _____________________

Very Good: __________________

Please list any specific health problems you are currently experiencing:

How would you rate your current sleeping habits?

Poor: _______ Satisfactory: _______ Unsatisfactory: ________

Good: ______ Very Good: ________

How many times per week do you generally exercise? ____________

What types of exercise do you participate in:

Are you currently experiencing any chronic pain?

Yes: ______

No: ______

If yes, please describe:

Please describe history of alcohol, cigarettes, and/or recreational drug use:

By signing below I am indicating that I consent to disclose this information to Growth and Gratitude, LLC

Print Name: ____

Signature:____

Date:____________________

Print Name: ____

Signature:____

Date:____________________