GROWTH AND GRATITUDE, PLLC

Online Therapy

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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: ☐

Other: ☐

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?

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 1-800-273-8255 for immediate support and consultation so that you can create a safety plan and partner with services in your are

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 you have experienced:

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 condition? ▢ _____

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 ▢

Unsatisfactory ▢

Satisfactory ▢

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?

No ▢

Yes ▢

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

Signature:_____
(Patient or Authorized Representative)
Date:_____

Signature:_____
(Patient or Authorized Representative)
Date:_____

Signature:_____
(Patient or Authorized Representative)
Date:_____