

**Lipscomb Family Therapy Center
Client Intake Form**

Completing this form is optional, and the choice to complete or not to complete this form will have no effect on your ability to be involved in therapy at the Lipscomb Family Therapy Center

Personal Title: <input type="checkbox"/> Mr. <input type="checkbox"/> Ms. <input type="checkbox"/> Miss <input type="checkbox"/> Mrs. <input type="checkbox"/> Dr.	Today's Date: _____	
Name: _____		
Last	First	Middle

Street Address: _____

City: _____

State: _____

Zip: _____

Birthdate: _____

Primary Phone: _____ Home Mobile Work

Other Phone: _____ Home Mobile Other:

Email: _____

Biological Sex: Male Female

Race/Ethnicity: White, Caucasian Black, African American Hispanic, Latino Asian
 Two or More Races Pacific Islander Native American Other:

Sexual Orientation: Heterosexual Homosexual Bisexual Other:

Relationship Status: Single Dating Partnered Living Together Engaged Married
 Separated Divorced Widowed

Highest Level of Education: Less than High School High School GED Some College
 College Graduate Advanced Degree Other:

Religion & Spirituality: Atheist Agnostic Christian Muslim Hindu Buddhist LDS
 Jew Sikh Bahá'í Other:

How important is your religion or spirituality to you?

<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Unimportant	Of Little	Moderately	Important	Very
	Importance	Important		Important

How did you hear about Lipscomb Family Therapy Center? Lipscomb University
 Lipscomb Academy A Family Member, Friend, or Coworker Other:

Emergency Contacts

Name	Address	Phone
1.		
2.		
3.		

Employment Information		
Employer:	Annual Household Income	
Position:		
Dates Employed:	<input type="checkbox"/> \$0 - \$10,000	<input type="checkbox"/> \$70,001 - \$80,000
Comments:	<input type="checkbox"/> \$10,001 - \$20,000	<input type="checkbox"/> \$80,001 - \$90,000
	<input type="checkbox"/> \$20,001 - \$30,000	<input type="checkbox"/> \$90,001 - \$99,999
	<input type="checkbox"/> \$30,001 - \$40,000	<input type="checkbox"/> \$100K - \$150K
	<input type="checkbox"/> \$40,001 - \$50,000	<input type="checkbox"/> \$151K - \$200K
	<input type="checkbox"/> \$50,001 - \$60,000	<input type="checkbox"/> \$201K - \$250K
	<input type="checkbox"/> \$60,001 - \$70,000	<input type="checkbox"/> > \$250K
Household Information (i.e., information about those who live with you)		
Name	Age	Relationship to You
1.		
2.		
3.		
4.		
5.		
6.		
7.		
Health Information		
Medical Doctor:	Phone:	
Psychiatrist:	Phone:	
Last Therapist:	Phone:	
Please list all medical or mental health conditions that you have now or have had previously (e.g., diabetes, depression, etc.):		
Please list all medications you are currently taking and what they are prescribed to treat (e.g., Lipitor for cholesterol, Zoloft for depression, etc.):		
How often do you exercise (i.e. planned, structured, and repetitive physical activity)? <input type="checkbox"/> Never <input type="checkbox"/> Monthly or Less <input type="checkbox"/> 2-4 x Monthly <input type="checkbox"/> 2-3 x Weekly <input type="checkbox"/> 4 or More x Weekly		
For how long do you exercise on average?		
Nightly Sleep: <input type="checkbox"/> 1-3 hours <input type="checkbox"/> 3-5 hours <input type="checkbox"/> 5-7 hours <input type="checkbox"/> 7-9 hours <input type="checkbox"/> > 9 hours		

Sleep Assessment
Sleep Quality: <input type="checkbox"/> Poor <input type="checkbox"/> Fair <input type="checkbox"/> Good <input type="checkbox"/> Excellent
Eating Habits: <input type="checkbox"/> I tend to over eat <input type="checkbox"/> I tend to under eat <input type="checkbox"/> I tend to eat healthy foods <input type="checkbox"/> I tend to eat unhealthy foods <input type="checkbox"/> I binge and/or purge sometimes
Please select the answer that best describes your behavior on average over the past 6 months:
Cigarette Use: <input type="checkbox"/> Nonsmoker <input type="checkbox"/> Less than half a pack daily <input type="checkbox"/> Up to one pack daily <input type="checkbox"/> More than one pack daily
Other Tobacco Use: <input type="checkbox"/> Non tobacco user <input type="checkbox"/> Once daily <input type="checkbox"/> Twice daily <input type="checkbox"/> Three or more times daily
Please refer to this information to answer the following questions: 1 Drink = 12 oz. of Beer, 8-9 oz. Malt Liquor, 5 oz. of Wine, 2-3 oz. of Liqueur, 1.5 oz. Hard Liquor
How frequently do you consume at least one drink containing alcohol? <input type="checkbox"/> Never <input type="checkbox"/> Monthly or Less <input type="checkbox"/> 2-4 x Monthly <input type="checkbox"/> 2-3 x Weekly <input type="checkbox"/> 4 or More x Weekly
How many drinks containing alcohol do you have on a typical day when you are drinking? <input type="checkbox"/> I do not drink alcohol <input type="checkbox"/> 1 or 2 <input type="checkbox"/> 3 or 4 <input type="checkbox"/> 5 or 6 <input type="checkbox"/> 7 to 9 <input type="checkbox"/> 10 or more
How often do you have six or more drinks on one occasion? <input type="checkbox"/> Never <input type="checkbox"/> Monthly or Less <input type="checkbox"/> 2-4 x Monthly <input type="checkbox"/> 2-3 x Weekly <input type="checkbox"/> 4 or More x Weekly
Have you ever felt you should cut down on your drinking? <input type="checkbox"/> Yes <input type="checkbox"/> No
Have people annoyed you by criticizing your drinking? <input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever felt bad or guilty about your drinking? <input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover? <input type="checkbox"/> Yes <input type="checkbox"/> No
How frequently do you use drugs (i.e. other than those prescribed by a doctor)? <input type="checkbox"/> Never <input type="checkbox"/> Monthly or Less <input type="checkbox"/> 2-4 x Monthly <input type="checkbox"/> 2-3 x Weekly <input type="checkbox"/> 4 or More x Weekly
Please name any drugs used during the past 6 months:
Health and Safety Check
Currently, how often are you having suicidal thoughts? <input type="checkbox"/> Never <input type="checkbox"/> Monthly or Less <input type="checkbox"/> 2-4 x Monthly <input type="checkbox"/> 2-3 x Weekly <input type="checkbox"/> 4 or More x Weekly
In the past, how often did you have suicidal thoughts? <input type="checkbox"/> Never <input type="checkbox"/> Monthly or Less <input type="checkbox"/> 2-4 x Monthly <input type="checkbox"/> 2-3 x Weekly <input type="checkbox"/> 4 or More x Weekly
Please describe the last time you had a suicidal thought and/or thought about hurting yourself:

Have you ever experienced any of the following? If yes, please indicate when.	
Depressed Mood: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Serious Mood Swings: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Neurological Issue (e.g. stroke): <input type="checkbox"/> Yes <input type="checkbox"/> No	
Anxiety: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Panic Attack <input type="checkbox"/> Yes <input type="checkbox"/> No	
Phobia: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Sexual Issues: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Sleep Disturbances: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Hallucinations: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Unexplained Loss of Time: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Unexplained Memory Lapse: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Frequent Body Complaints: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Eating Disorder: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Body Image Issues: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Repetitive Thoughts: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Repetitive Behaviors: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Homicidal Thoughts: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Thoughts of Death: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Thoughts of Self-Harm <input type="checkbox"/> Yes <input type="checkbox"/> No	
Thoughts of Harming Others: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Other: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Therapy Goals	
What do you hope to accomplish in therapy?	
List up to 3 things that will be different that indicate you will no longer need to attend therapy?	