Solutions Therapy

18 Kings Highway, Middletown NJ 07744

Suite 102

Phone: (908) 670-4672

This confidential, multi-faceted, intake form helps us understand different parts and pieces to who you are as a person. Although some questions may seem irrelevant to your care, they will play a role in our core understanding of current and past issues and help us build and develop an integrative treatment plan.

Client Information

Today's Date: _____ Date of Birth:_____

Client Name:_____ Sex: M F

Address:_____ City:_____

State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____ May we email you? _____

Emergency Name and Contact Number: _____

Counseling Information

Please describe the difficulties you are having that have brought you to our office: _____

_____

_____

What has contributed to these difficulties? _____

_____

What are your goals in seeking treatment?_____

_____

Have you been in treatment with a psychologist or psychiatrist before and if so for what? _____

_____

How long were you in treatment before: _____

What was the name of your prior counselor?_____

What else would be helpful for us to know: _____

Have you experienced any significant trauma or loss in your life, and if applicable, please indicate what and when:

_____

Employment Information

Employer: _____ Address: _____

Work Phone: _____ Occupation: _____

How would you rate your enjoyment of your job: (Low) 1 2 3 4 5 6 7 8 9 10 (High)

What about your job do you enjoy? _____

What about your job do you dislike? _____

What is your dream job? _____

Educational Background/Information

School: _____ School Address: _____

Date you graduated or expect to graduate: _____

What are you studying? _____

What are your educational goals? _____

Family Information

Marital Status: Single Married Divorced Separated Widowed Committed-Relationship

How many people live in your household: _____

Do you live with a roommate? _____

Do you have children? _____

If so, what are your children's names and ages? _____

_____

Do you live in a group home or residential treatment center?_____

Are you part of a blended/step-family? _____

Will other friends or family members be participating in your counseling? _____

If so, who will be participating: _____

If you are in a romantic relationship, how would you rate your relationship with your partner? (Low) 1 2 3 4 5 6 7 8 9 10 (High)

Health Information

Are you currently under the care of a physician for any medical issue(s), and if so, please indicate:

_____

Are you currently taking any prescribed medications, and if so, what:

_____

Have you ever been treated or hospitalized for a psychiatric condition, suicide, drug/alcohol/substance abuse issue? _____

Does anyone in your family have a mental or psychiatric condition? _____

Have you ever been diagnosed with Bi-Polar Disorder? If so, when? _____ How would you rate your energy level in the past 4 weeks?

(Low) 1 2 3 4 5 6 7 8 9 10 (High)

How would you rate your current physical health?

(Low) 1 2 3 4 5 6 7 8 9 10 (High)

How would you rate your current emotional health?

(Low) 1 2 3 4 5 6 7 8 9 10 (High)

How would you rate your general happiness and wellbeing?

(Low) 1 2 3 4 5 6 7 8 9 10 (High)

In the past 4 weeks how would you rate your ability in being able to relax?

(Low) 1 2 3 4 5 6 7 8 9 10 (High)

How would you rate your current stress level?

(Low) 1 2 3 4 5 6 7 8 9 10 (High)

What would you indicate are major stressors in your life? _____

_____

What are some ways that you have found are effective in helping you relieve stress? _____

_____

How well do you nourish yourself with healthy/balanced food?

(Low) 1 2 3 4 5 6 7 8 9 10 (High)

How well do you nourish yourself with love/laughter?

(Low) 1 2 3 4 5 6 7 8 9 10 (High)

How well do you nourish yourself with words of self-encouragement?

(Low) 1 2 3 4 5 6 7 8 9 10 (High)

How well do you nourish yourself with self-care?

(Low) 1 2 3 4 5 6 7 8 9 10 (High)

What was the last book you read? _____

Who are some of your favorite musicians: _____

What do you do to have fun? _____

Do you currently take any nutritional supplements, vitamins, herbals, essential oils: _____

_____

Do you have any difficulty falling asleep or staying asleep? _____

About how many hours of sleep do you average per night? _____

Do you awaken from sleep feeling rested? _____

Do you participate in any type of exercise activity, and if so, what and how often? _____

_____

Have you ever practiced Yoga? _____ If so, what was your experience like? _____

_____

Have you ever practiced Meditation? _____ If so, what was your experience like? _____

_____

If not, what are the barriers preventing you from meditating? _____

Do you think that meditation would help you with your current issue? _____

Referral Information

Whom may we thank for referring you to this office: _____

Are you in my office for: Referral Employee Assistance Program Insurance Website
Juvenile Court Referral Psychiatrist Referral Psychologist Referral School Referral
Hospital Referral Other: _____

Insurance Information

Name of Insured: _____ Relationship to you: _____
Date of Birth of Insured: _____ Insurance Name/Type: _____
Insurance Address: _____ Insurance Phone: _____
Insurance ID Number: _____ Group ID Number: _____

Client Name/Signature/Date

Client/Guardian Name:	Signature:
Date:	