Lynda Phillips, LCMHC, NCC. New York license no: 007554-1. NCC no: 328939
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Phillips Mental Health Counseling, P.C.

Form # 4: CLIENT CONTACT INFORMATION SHEET

Birth Date: _____ Age: _____

Gender: o Male o Female

Name: _____

Address (Street and Number):_____

City: _____ State: _____ Zip: _____

Home Phone: _____

May We Leave a Message on your cell/other phone: Yes __ or No __

Cell/other Phone number: _____

May We Leave a Message on your home phone: Yes ___ or No ___

E-mail: _____

May We Email You? Yes___ 0r No ____

*please note: Email correspondence is not considered to be a confidential medium of communication.

Occupation: _____

Place of Employment: _____

Work Number: _____

If needed, is it ok to call you at work? Yes ___ or No ___

Emergency Contact name: _____

And phone number _____

Date of your first appointment: _____

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

Referred by:

Medical Provider: __ • Insurance Provider __ • My Website: __ • Psychology Today: __
Friend/Family: ___ • Other: _____

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CLIENT INTAKE FORM

Have you previously received any mental health services? Yes ___ or 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
- ☐ 2 years
- ☐ During adolescence
- ☐ During childhood

What areas of your life have been affected because of this problem?

_____

Are you currently experiencing overwhelming sadness, grief or depression? Yes ___ or No ___

If yes, for approximately how long? _____

Are you currently experiencing anxiety, panic attacks or have any phobias? Yes ___ or No ___

If yes, when did you begin experiencing this? _____

_____

Please describe any significant losses or traumas you have experienced:

_____

_____

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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

Where were you born? _____

Where did you grow up? _____

City ____ Suburbs _____ Country _____

Father's occupation? _____

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.).

Condition	**Please circle**	**List family member name**
Alcohol/Substance Abuse	yes/no	_____
Anxiety	yes/no	_____
Depression	yes/no	_____
Domestic Violence	yes/no	_____
Sexual Abuse	yes/no	_____
Eating Disorders	yes/no	_____
Obesity	yes/no	_____
Obsessive Compulsive Disorder	yes/no	_____
Schizophrenia	yes/no	_____
Suicide Attempts	yes/no	_____

Other diagnosed mental health condition? Yes __no __ : which was _____

Marital Status: Married ___or single____ Never Married ___ Domestic Partner yes __ No __

Separated ___ Divorced ____ for how long? _____

Widowed: ____Please provide your partner's name and year deceased:
_____

If married, how long have you been married for and what is your partners name:

_____

On a scale of 1-10 (best), how would you rate your relationship? _____

Are you currently in a romantic relationship? Yes ___ how long? _____ No ___

Physical Health

Medication/Supplement _____

Dosage/Condition name _____ Began/Stopped: _____

Prescribing provider and contact information: _____

Name: Specialty: _____

Facility: Phone, email, or Fax: _____

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

If you are having problems, in which phase of sleep are you experiencing issues?

- Falling asleep •
- Staying asleep
- Awakening early • Sleep apnea

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Please list any other specific sleep problems you are currently experiencing:

_____

How many times per week do you exercise? _____

What types of exercise do you participate in:

_____

Are you currently experiencing any chronic pain? No ____ or Yes ____

If yes, please describe: _____

Please describe the current use of alcohol, cigarettes, and/or recreational drugs:

_____

Please describe the previous use of alcohol, cigarettes, and recreational drugs:

_____

Additional Information:

What do you enjoy about your work (full-time homemaker included)? If retired, what did you enjoy about your work? _____

_____

What do you find particularly stressful about your current or previous work?

_____

What do you enjoy doing in your free time? What do you do to relax?

_____

Do you consider yourself to be spiritual or religious? If yes, please describe your faith or belief:

_____

What do you see as some of your strengths? _____

_____

What do you see as some of your weakness? _____