



Science and Spirituality for Personal Transformation

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www.VitalChanges.org

CLIENT INTAKE FORM

CLIENT INFORMATION

NAME: DATE:

YOUR MAIN CONCERN:

Referred by: VitalChanges.org web site; VitalCouples.com web site; Insurance web site; Other

Date of Birth: Age: Gender:

Ethnic Identity: Languages:

Spirituality/religious affiliation:

Education: Housing

Are you in Crisis? Yes / No

If yes, what is the crisis:

What is the outcome you like to see as a result of therapy?

Marital/Relationship Status:

Assessment of current relationship (if applicable): Good Fair Poor

Social Relationships

Check how you generally get along with other people: (check all that apply)

Affectionate Aggressive Avoidant Fight/argue often Follower
 Friendly Leader Outgoing Shy/withdrawn Submissive
 Other (specify): _____

Sexual orientation: _____ Comments: _____

Sexual dysfunctions? Yes _____ No

If Yes, describe: _____

Any current or history as sexual perpetrator? Yes No

If Yes, describe: _____

Leisure/Recreational

Describe special areas of interest or hobbies (e.g., art, books, crafts, physical fitness, sports, outdoor activities, church activities, walking, exercising, diet/health, hunting, fishing, bowling, traveling, etc.)

Activity	How often now?	How often in the past?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Physical Health

Name of Primary Care Physician: _____

May I contact your physician if necessary? Yes / No _____ [Please initial]

List any major health problems for which you currently receive treatment:

List any medications which you are now taking:

Current prescribed medications	Dose	Dates	Purpose	Side effects
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Current over-the-counter meds	Dose	Dates	Purpose	Side effects
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Do you have any blood relatives with a history of mental emotional disorders? If so, please describe their conditions and any medications that they used and any difficulties they had. _

Please check if there have been any recent changes in the following:

___ Sleep patterns ___ Eating patterns ___ Behavior ___ Energy level
 ___ Physical activity level ___ General disposition ___ Weight ___ Nervousness/tension

Describe changes in areas in which you checked above: _____

Chemical Use History

Name of Substance	Method of use	Frequency and amount	Age of first use	Age of last use	Used in last 48 hours		Used in last 30 days		
					Yes	No	Yes	No	
_____	/	/	/	/	/	Yes	No	Yes	No
_____	/	/	/	/	/	Yes	No	Yes	No
_____	/	/	/	/	/	Yes	No	Yes	No
_____	/	/	/	/	/	Yes	No	Yes	No

Please check behaviors and symptoms that occur to you more often than you would like them to take place:

- | | | |
|-------------------------|-------------------------|----------------------------|
| ___ Aggression | ___ Elevated mood | ___ Phobias/fears |
| ___ Alcohol dependence | ___ Fatigue | ___ Recurring thoughts |
| ___ Anger | ___ Gambling | ___ Sexual addiction |
| ___ Antisocial behavior | ___ Hallucinations | ___ Sexual difficulties |
| ___ Anxiety | ___ Heart palpitations | ___ Sick often |
| ___ Avoiding people | ___ High blood pressure | ___ Sleeping problems |
| ___ Chest pain | ___ Hopelessness | ___ Speech problems |
| ___ Cyber addiction | ___ Impulsivity | ___ Suicidal thoughts |
| ___ Depression | ___ Irritability | ___ Thoughts disorganized |
| ___ Disorientation | ___ Judgment errors | ___ Trembling |
| ___ Distractibility | ___ Loneliness | ___ Withdrawing |
| ___ Dizziness | ___ Memory impairment | ___ Worrying |
| ___ Drug dependence | ___ Mood shifts | ___ Other (specify): _____ |
| ___ Eating disorder | ___ Panic attacks | _____ |

Briefly discuss how the above symptoms impair your ability to function effectively: _____

PLEASE DESCRIBE YOUR CURRENT CONDITION [PAST 3-4 WEEKS] REGARDING:

FEELINGS OF SADNESS: _____

FEELINGS OF HOPELESSNESS: _____

FEELING LIFE IS WORTH LIVING: _____

FEELING THAT LIFE IS NOT WORTH LIVING: _____

RELATIONSHIP CONFLICTS: _____

SUPPORTIVE RELATIONSHIPS: _____

EMPLOYMENT SATISFACTION: _____

PAST COUNSELING ISSUES: _____

VIOLENCE IN HOME: _____

PAST SEXUAL, EMOTIONAL, PHYSICAL ABUSE: _____

Billing Information

Client Name: _____ Date of Birth: _____

Address: _____

Home phone: _____ Work phone: _____

Cell phone: _____ Email: _____

[√ Check preferred contact numbers]

INSURANCE COMPANY: _____

POLICY NUMBER: _____ GROUP NUMBER: _____

NAME OF INSURED: _____

SECONDARY INSURANCE COMPANY: _____

POLICY NUMBER: _____ GROUP NUMBER: _____

NAME OF INSURED: _____

Payments, co-payments, and deductible amounts are due at the time of service. There is a 1% per month (12% Annual Percentage Rate) interest charge on all accounts that are not paid within 60 days of the billing date.

I HEREBY CERTIFY that I have read and agree to the conditions and have received a copy of the Federal Truth in Lending Disclosure Statement for Professional Services.

Person responsible for account: _____ Date: ____/____/____

Release of Information Authorization to Third Party

I (we) authorize **Vital Changes, Inc.** to disclose case records (diagnosis, case notes, psychological reports, testing results, or other requested material) to the above listed third-party payer or insurance company for the purpose of receiving payment directly to **Vital Changes, Inc.**

I (we) understand that access to this information will be limited to determining insurance benefits, and will be accessible only to persons whose employment is to determine payments and/or insurance benefits. I (we) understand that I (we) may revoke this consent at any time by providing written notice, and after one year this consent expires. I (we) have been informed what information will be given, its purpose, and who will receive it. I (we) certify that I (we) have read and agree to the conditions and have received a copy of this form.

Person(s) responsible for account: _____ Date: ____/____/____

Person(s) receiving services: _____ Date: ____/____/____

Person(s) or guardian(s): _____ Date: ____/____/____

Signature: _____ Date _____