vitalchanges
Science and Spirituality for Personal Transformation

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# 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☐ Friendly ☐ Leader ☐ Outgoing ☐ Shy/withdrawn ☐ Submissive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 Heath**

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 |

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

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

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 _____