InnerWell
Integrative Counseling Services
229 Western Avenue • Brattleboro, VT 05301 • 802-258-7014 • www.InnerWell.org

CLIENT INTAKE FORM

Name _____ Today's Date ___/___/___

Street Address _____ Date of Birth ___/___/___

City, State, Zip _____ Current Age _____

Preferred phone _____ (cell/home/work) Secondary phone _____(cell/home/work)
☐ Okay to leave confidential messages at this number ☐ Okay to leave confidential messages at this number

E-mail address _____ Occupation _____

Referred by _____

In case of emergency, you have my permission to notify:

Name _____ Phone _____ Relationship to you:_____

Insurance

☐ I prefer to pay privately and not involve an insurance company in my counseling.

☐ I plan to submit receipts to my insurance company for potential partial reimbursement.

I understand that I am responsible for paying all charges in full at the time of service, and that InnerWell is a non-contracted provider and does not guarantee reimbursement. I authorize my InnerWell therapist to provide a mental health diagnosis code on my receipts, which I understand will become part of my medical record and is required by all insurance companies. I also authorize disclosure about my treatment, treatment planning, progress, and session attendance to my insurance company by InnerWell in the interest of facilitating use of my covered insurance benefits.

Insurance Plan: _____ Policy #_____ Name of Policy Holder:_____

Background

Marital/Relationship status _____ (partner/spouse's first name _____)

Children's names & ages (if any) _____

Have you received psychotherapy or counseling before? (Yes / No). If so, please indicate dates of treatment and reason for starting and stopping.

Health History

Current health concerns _____

Psychiatrist (if any)_____ Phone _____

Current medications (include dose & frequency) _____

Prior medication use & dates _____

Any psychiatric hospitalizations? If so, when? _____

Have you ever felt suicidal? _____ When was the last time? _____

Non-prescription drugs/alcohol/smoking/caffeine (include amount & frequency) _____

_____

What do you do for exercise, and how often? _____

Current issues

Please indicate any areas of your life which are especially challenging at this time (mark with a "C"), and any which feel particularly satisfying or nourishing at this time (mark with an "S").

career path	**health & body**	**family relationships**	**finances**
intimacy/sexuality	**parenting**	**(finding) life partner**	**housing**
spiritual life	**work relationships**	**life balance**	**social life/ friendships**
transitions	**environmental/political concerns**	**other _____**	

Please indicate which of the following, if any, are present in your life by circling the appropriate number after each item.

	never	*occasional*	*often*	*always*
easily stressed	1	2	3	4
anxiety	1	2	3	4
panic attacks	1	2	3	4
cry easily / overly emotional	1	2	3	4
irritability	1	2	3	4
obsessive thinking	1	2	3	4
mood swings	1	2	3	4
anger and explosivity	1	2	3	4
feeling powerless when facing conflict	1	2	3	4
thoughts of revenge	1	2	3	4
nightmares	1	2	3	4
difficulty sleeping	1	2	3	4
difficulty relating to groups	1	2	3	4
difficulty relating to intimate partner	1	2	3	4
gastrointestinal complaints	1	2	3	4
headaches and migraines	1	2	3	4
back or neck pain	1	2	3	4
widespread muscle tension and/or myalgia	1	2	3	4
feeling separate from your body	1	2	3	4
feeling your surroundings are unreal	1	2	3	4
intolerance to light and/or sound	1	2	3	4
sexual problems	1	2	3	4
troubling fantasies	1	2	3	4
eating disorders or food-related issues	1	2	3	4
alcohol or drug dependence	1	2	3	4
workaholism	1	2	3	4
self-injury	1	2	3	4
low energy and fatigue	1	2	3	4
depression	1	2	3	4
feelings of loneliness	1	2	3	4
low self-esteem	1	2	3	4
shame	1	2	3	4
other: _____	1	2	3	4

Trauma History (if any)
Did you have traumatic experiences in your childhood and adolescence (e.g. emotional neglect, abuse by a caregiver, car accident, discrimination, divorce of parents, loss of loved ones, school or sibling bullying)?
___ Yes ___ No ___ I don't know
Brief description (optional):

Any traumatic experiences or significant losses in your adult life? ___ Yes ___ No ___ I don't know
Brief description (optional):

How have these impacted your life?

Supports
What are your primary coping strategies? How well do these work for you?

Who are your primary social supports?

Goals for Therapy
Please describe your current symptoms and reasons for coming to therapy.

If this therapy is successful, what will be different in your life?

Is there anything else that would you like me to know about you at this point?

Signature _____ Date _____