Revised 10/25/16

Lake Mead
WELLNESS CENTER

311 Water Street
Henderson, NV 89015
702.900.5040

Intake Form

Personal Information:

Name:_____ Birth date_____

Address:_____
Street City Zip

Cell phone:_____ Home phone:_____ Age: _____

[ ] Ok to leave message [ ] Ok to text Preferred method of contact: [ ] Text [ ] Phone [ ] Email

Sex: _____ Referred by: _____

Employer: _____ Position:_____ Years:_____

Marital Status (circle one):

Married # of years_____

Divorced # of years_____

Single

Widowed

Cohabitating # of years_____

*If you would like to be added to our mailing list for our every now and then newsletter, sharing resources and upcoming groups, please opt in by giving us your email address here:

_____

Spouse/Partner Info:

Spouse: _____Age: _____Birth date: _____

Occupation: _____ Years employed: _____

Cell Phone:_____ Home phone:_____ Best time to contact _____

Marriage Info:

Date of marriage _____ Length of dating _____

Attending therapy with: _____

Any previous marriages: _____Yes _____ No If yes, #_____ Length of marriage(s) _____

How did previous marriages end?

_____

_____

Other Members of Household

1. Name:_____ Male or Female

Age:_____ Relationship:_____

2. Name:_____ Male or Female

Age:_____ Relationship:_____

3. Name:_____ Male or Female

Age:_____ Relationship:_____

4. Name:_____ Male or Female

Age:_____ Relationship:_____

Children not currently living with you:

Name:_____ Age:_____

Name:_____ Age:_____

Name:_____ Age:_____

In the case of an emergency contact: Name:_____

Contact #_____ Relationship:_____

Therapy Information

Previous therapy? ____Yes ____No Currently in therapy elsewhere? ____Yes ____No

If yes describe when and where:_____

Have you been diagnosed with any chronic condition?_____

Previous diagnosis (both medication and psychological):_____

Are you currently on medications? ____Yes ____ No

If yes, which ones? _____

Have you had any previous inpatient psychiatric and/or drug/alcohol rehab or hospitalizations?

____Yes ____ No If yes, please describe.

_____

Reasons for attending therapy (sources of stress that brought you to therapy):

1. _____

2. _____

3. _____

Goals for Therapy:

1. _____

2. _____

3. _____

Current Functioning:

Please circle on the following scale to indicate how well you are coping at the present time. 100% means that you are coping the best that you can considering your situation:

0%------10%------20%------30%------40%------50%------60%------70%------80%------90%------100%

Social Network:

Religious affiliation if any: _____

Church Affiliation_____ Do you attend any services? ____Yes ____No

How often?_____

What best describes current relationships you have with friends (check one)?

____I have several strong friendships ____I have a few close friends ____ I have no friendships

What describes current relationships with family (check one)?

___I am close and feel support with family

___I am close to some family but others are a great source of frustration or stress

___I have no family close by

___I have family close by but they are a source of great tension and/or danger.

Home Environment:

I have been violent in the home (circle) Never Just a little Pretty much Very much N/A

Please describe:_____

My spouse has been violent (circle) Never Just a little Pretty much Very much N/A

Please describe: _____

My children have witnessed violence (circle) Never Just a little Pretty much Very much N/A

Please describe: _____

Other comments:

_____

_____

Problem Checklist (circle all that apply):

Abused as child	Sexual troubles	Children	Work problems
Fear	Apathy	Infertility	Eating disorders
Post abortion trauma	Grief/Loss	Unresolved conflicts	Mood swings
Addictions	Sleep troubles	Control Issues	A vice
Financial Troubles	Blended family issues	In-law/Parent problems	Employment issues
Rebellion	Guilt/Shame	Violence in the home	Parent/child conflict
Anger/Bitterness	Spousal conflicts	Communication issues	Divorce issues
Gambling	Change in lifestyle	Life transition problems	Spiritual problems
Same sex preference	Health problems	Low self-esteem	Sexual abuse (child or adult)
Anxiety or panic attack	Suicidal thoughts	Depression	
Gluttony	Suicidal actions	Memory Problems	Marital trouble

Do you currently consume alcohol? ___Yes ___No

If yes, then answer questions below:

Date of last use_____ Amount_____ # of years used_____

Frequency? ___ Daily ____ 2-3x week ___Weekly ___ Monthly ___ Less than once a month

Do you currently use any substances (drugs or prescription drugs)? ____Yes ____ No

If yes, answer questions below:

Frequency? ___ Daily ____ 2-3x week ___Weekly ___ Monthly ___ Less than once a month

Describe any problems that affect your daily functioning (job, relationship, sleep, ability to care for yourself or your children). _____

_____

Family History:

Does your family have any history of, mental illness, suicide, depression, substance abuse, eating disorders (anorexia, bulimia, binge eating), or other addictions (please describe if yes)?

_____

_____

Please list any family health problems:

_____

_____

In your opinion, how many sessions do you think you will need to get back on track?

___ Don't know ___ 1-3 sessions ___4-6 sessions ____7-9 sessions ___10-12 sessions

Other additional information:

_____

_____

_____

_____