KATY FITZGERALD

Clinical Social Worker/Therapist, LCSW

CLIENT INTAKE

Please complete this form to the best of your ability. Information provided here is protected as confidential information. Please bring to your first session.

Client Name_____ Gender: ☐ M ☐ F ☐ Other Date of Birth_____ Age_____

Marital Status: ☐ never married ☐ married ☐ divorced ☐ widowed ☐ separated ☐ living as married ☐ other

Address_____ City, State, Zip_____

Home number_____ May I leave a message? ☐ Y ☐ N Cell_____ May I leave a message? ☐ Y ☐ N

Email_____ *(email is not a confidential form of communication, please acknowledge if consent to using it ☐ yes ☐ no).*

Emergency Contact Information: (must be completed):

Name_____ Relationship_____

Address_____ City, State, Zip_____

Phone number_____ In the case of medical emergency, I give permission to Katy Fitzgerald to seek emergency medical care:_____ initial

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Physical Health History

Describe your current physical health: ☐ very good ☐ good ☐ fair ☐ poor

Are you allergic to anything? (medicines, food, environmental) ☐ yes ☐ no Describe: _____

_____

Describe current/past health issues:_____

Describe your exercise routine:_____

Describe your sleep pattern:_____

Describe your nutrition/eating:_____

Eating issues: ☐ Loss of control over eating ☐ binging/purging behavior ☐ rules about eating ☐ emotional eating

Describe any pain issues that you have:_____

Have you had any serious illness, surgeries or hospitalizations (medical)? ☐ yes ☐ no Describe: _____

_____

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Are you currently taking medication for medical reasons? ☐ yes ☐ no

NAME	DOSE	PURPOSE

Are you currently taking any vitamins, supplements, herbals? ☐ yes ☐ no

Do you have a primary care provider? ☐ yes ☐ no Name_____

Address_____ City, State, Zip_____

May Katy Fitzgerald communicate with your medical professionals to coordinate care? ☐ yes ☐ no

Medical Health History:

Describe your current mental health: ☐ very good ☐ good ☐ fair ☐ poor

Please check if you have experienced the following symptoms for more than 2 weeks in the last 4 weeks.

DEPRESSION	not at all	1–2 days	more than 1/2	all days
Depressed mood	☐	☐	☐	☐
Little interest in doing things	☐	☐	☐	☐
Trouble falling, staying asleep, over sleeping	☐	☐	☐	☐
Feeling tired, low energy	☐	☐	☐	☐
Poor appetite/overeating	☐	☐	☐	☐
Feeling badly about self	☐	☐	☐	☐
Difficulty concentrating	☐	☐	☐	☐
Thoughts of dying, wanting to die, self harming	☐	☐	☐	☐

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MANIA	not at all	1–2 days	more than 1/2	all days
Elevated mood	☐	☐	☐	☐
Decreased need for sleep	☐	☐	☐	☐
Racing thoughts	☐	☐	☐	☐
Irritability	☐	☐	☐	☐

ANXIETY	not at all	1–2 days	more than 1/2	all days
Anxiety, excessive worrying	☐	☐	☐	☐
Obsessive thoughts or behaviors	☐	☐	☐	☐
Phobias	☐	☐	☐	☐
Trauma- nightmares, flashbacks, hyper-vigilance, avoidance of trauma	☐	☐	☐	☐
Panic attacks (sweating, heart racing, feeling choked, hot flashes, dizziness...)	☐	☐	☐	☐

OTHER SYMPTOMS	yes	no
Paranoid thoughts	☐	☐
Hearing/seeing things that others don't hear/see	☐	☐
History of violence	☐	☐
Homicidal thoughts or plans	☐	☐
Distorted body image	☐	☐
ADD/ADHD	☐	☐
History of trauma	☐	☐
History of suicide attempt	☐	☐

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Have you ever been hospitalized for psychiatric reasons? ☐ yes ☐ no

Describe:_____

Please complete this table for psychiatric or substance abuse providers. Please attach additional sheet, if necessary:

DOCTOR/THERAPIST	LOCATION	DATES	REASONS

How often do you use alcohol: ☐ daily ☐ 3–5x/week ☐ 1–2x/week ☐ monthly ☐ less than 1x/mo ☐ none ☐ in recovery Describe:_____

How often do you use non-prescribed (illegal) drugs: ☐ daily ☐ 3–5x/week ☐ 1–2x/week ☐ monthly ☐ less than 1x/mo ☐ none ☐ in recovery Describe:_____

How much caffeine do you have daily:_____

Personal History/Demographics:

Describe significant life changes or stressful events that you have had recently: _____

_____

Are you currently in a significant relationship? ☐ yes ☐ no Describe: _____

_____

Describe your education? _____

_____

Describe your work situation? _____

_____

Family Income: ☐ less than $25K ☐ $25–50,000 ☐ $50–75,000 ☐ more than $75,000

Describe your race and/or ethnicity: _____

Describe your faith or spiritual beliefs: _____

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Have you experienced any of the following: ☐ divorce ☐ significant loss ☐ losing a job ☐ debt/financial problems ☐ legal issues ☐ trauma ☐ victim of crime ☐ discrimination ☐ chronic health issues ☐ family problems ☐ other:_____

Identify 3 strengths:_____ _____ _____

Identify 3 weaknesses:_____ _____ _____

What would you like to accomplish in therapy?_____

_____

Is there anything else that is important for me to know? _____

_____

_____

Client signature: _____ Date: _____

Therapist signature: _____ Date: _____

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