LIPSCOMB UNIVERSITY

Lipscomb Family Therapy Center

Lipscomb Family Therapy Center
Client Intake Form

Completing this form is optional, and the choice to complete or not to complete this form will have no affect on your ability to be involved in therapy at the Lipscomb Family Therapy Center

Personal Title: ☐Mr. ☐Ms. ☐Miss ☐Mrs. ☐Dr. **Today's Date:**

Name: _____
Last First Middle

Street Address:

City:

State:

Zip:

Birthdate:

Primary Phone: ☐Home ☐Mobile ☐Work

Other Phone: ☐Home ☐Mobile ☐Other:

Email:

Biological Sex: ☐Male ☐Female

Race/Ethnicity: ☐White, Caucasian ☐Black, African American ☐Hispanic, Latino ☐Asian ☐Two or More Races ☐Pacific Islander ☐Native American ☐Other:

Sexual Orientation: ☐Heterosexual ☐Homosexual ☐Bisexual ☐Other:

Relationship Status: ☐Single ☐Dating ☐Partnered ☐Living Together ☐Engaged ☐Married ☐Separated ☐Divorced ☐Widowed

Highest Level of Education: ☐Less than High School ☐High School ☐GED ☐Some College ☐College Graduate ☐Advanced Degree ☐Other:

Religion & Spirituality: ☐Atheist ☐Agnostic ☐Christian ☐Muslim ☐Hindu ☐Buddhist ☐LDS ☐Jew ☐Sikh ☐Bahá'í ☐Other:

How important is your religion or spirituality to you?

☐1	☐2	☐3	☐4	☐5
Unimportant	Of Little Importance	Moderately Important	Important	Very Important

How did you hear about Lipscomb Family Therapy Center? ☐Lipscomb University ☐Lipscomb Academy ☐A Family Member, Friend, or Coworker ☐Other:

Emergency Contacts

Name	Address	Phone
1.		
2.		
3.		

Employment Information		
Employer: **Position:**	**Annual Household Income**	
Dates Employed: **Comments:**	☐ $0 - $10,000 ☐ $10,001 - $20,000 ☐ $20,001 - $30,000 ☐ $30,001 - $40,000 ☐ $40,001 - $50,000 ☐ $50,001 - $60,000 ☐ $60,001 - $70,000	☐ $70,001 - $80,000 ☐ $80,001 - $90,000 ☐ $90,001 - $99,999 ☐ $100K - $150K ☐ $151K - $200K ☐ $201K - $250K ☐ > $250K

Household Information (i.e., information about those who live with you)		
Name	**Age**	**Relationship to You**
1.		
2.		
3.		
4.		
5.		
6.		
7.		

Health Information	
Medical Doctor:	**Phone:**
Psychiatrist:	**Phone:**
Last Therapist:	**Phone:**
Please list all medical or mental health conditions that you have now or have had previously (e.g., diabetes, depression, etc.):	
Please list all medications you are currently taking and what they are prescribed to treat (e.g., Lipitor for cholesterol, Zoloft for depression, etc.):	
How often do you exercise (i.e. planned, structured, and repetitive physical activity)? ☐ Never ☐ Monthly or Less ☐ 2-4 x Monthly ☐ 2-3 x Weekly ☐ 4 or More x Weekly	
For how long do you exercise on average?	
Nightly Sleep: ☐ 1-3 hours ☐ 3-5 hours ☐ 5-7 hours ☐ 7-9 hours ☐ > 9 hours	

Sleep Assessment
Sleep Quality: ☐ Poor ☐ Fair ☐ Good ☐ Excellent
Eating Habits: ☐ I tend to over eat ☐ I tend to under eat ☐ I tend to eat healthy foods ☐ I tend to eat unhealthy foods ☐ I binge and/or purge sometimes
Please select the answer that best describes your behavior on average over the past 6 months:
Cigarette Use: ☐ Nonsmoker ☐ Less than half a pack daily ☐ Up to one pack daily ☐ More than one pack daily
Other Tobacco Use: ☐ Non tobacco user ☐ Once daily ☐ Twice daily ☐ Three or more times daily
Please refer to this information to answer the following questions: 1 Drink = 12 oz. of Beer, 8-9 oz. Malt Liquor, 5 oz. of Wine, 2-3 oz. of Liqueur, 1.5 oz. Hard Liquor
How frequently do you consume at least one drink containing alcohol? ☐ Never ☐ Monthly or Less ☐ 2-4 x Monthly ☐ 2-3 x Weekly ☐ 4 or More x Weekly
How many drinks containing alcohol do you have on a typical day when you are drinking? ☐ I do not drink alcohol ☐ 1 or 2 ☐ 3 or 4 ☐ 5 or 6 ☐ 7 to 9 ☐ 10 or more
How often do you have six or more drinks on one occasion? ☐ Never ☐ Monthly or Less ☐ 2-4 x Monthly ☐ 2-3 x Weekly ☐ 4 or More x Weekly
Have you ever felt you should cut down on your drinking? ☐ Yes ☐ No
Have people annoyed you by criticizing your drinking? ☐ Yes ☐ No
Have you ever felt bad or guilty about your drinking? ☐ Yes ☐ No
Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover? ☐ Yes ☐ No
How frequently do you use drugs (i.e. other than those prescribed by a doctor)? ☐ Never ☐ Monthly or Less ☐ 2-4 x Monthly ☐ 2-3 x Weekly ☐ 4 or More x Weekly
Please name any drugs used during the past 6 months:
Health and Safety Check
Currently, how often are you having suicidal thoughts? ☐ Never ☐ Monthly or Less ☐ 2-4 x Monthly ☐ 2-3 x Weekly ☐ 4 or More x Weekly
In the past, how often did you have suicidal thoughts? ☐ Never ☐ Monthly or Less ☐ 2-4 x Monthly ☐ 2-3 x Weekly ☐ 4 or More x Weekly
Please describe the last time you had a suicidal thought and/or thought about hurting yourself:

Have you ever experienced any of the following?		If yes, please indicate when.
Depressed Mood:	☐Yes ☐No	
Serious Mood Swings:	☐Yes ☐No	
Neurological Issue (e.g. stroke):	☐Yes ☐No	
Anxiety:	☐Yes ☐No	
Panic Attack	☐Yes ☐No	
Phobia:	☐Yes ☐No	
Sexual Issues:	☐Yes ☐No	
Sleep Disturbances:	☐Yes ☐No	
Hallucinations:	☐Yes ☐No	
Unexplained Loss of Time:	☐Yes ☐No	
Unexplained Memory Lapse:	☐Yes ☐No	
Frequent Body Complaints:	☐Yes ☐No	
Eating Disorder:	☐Yes ☐No	
Body Image Issues:	☐Yes ☐No	
Repetitive Thoughts:	☐Yes ☐No	
Repetitive Behaviors:	☐Yes ☐No	
Homicidal Thoughts:	☐Yes ☐No	
Thoughts of Death:	☐Yes ☐No	
Thoughts of Self-Harm	☐Yes ☐No	
Thoughts of Harming Others:	☐Yes ☐No	
Other:	☐Yes ☐No	

Therapy Goals

What do you hope to accomplish in therapy?

List up to 3 things that will be different that indicate you will no longer need to attend therapy?