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CLIENT INTAKE (CaIVCB)

Please provide the following information and answer ALL the questions below. Please note: All of information that you provide is protected as confidential information.

Date: _____

Last Name: _____ First Name _____ MI _____

Other Names Used: _____

Address: _____

City _____ State _____ Zip _____

GENDER: Male Female AGE: _____ D.O.B: _____ SSN: _____

E-mail: _____

*Please note: Email correspondence is not considered to be a confidential medium of communication.

Phone: (Home) _____ (Cell) _____ (Work) _____

May we leave a message? Yes No

Communication Preferences for appointment reminder? Email Text Both None

RACE AND ETHNICITY: (Mark all that apply)

White African American Hispanic/Latino Ethnicity Asian Filipino

Pacific Islander Native American American Indian Middle Eastern

Other: _____

REASON FOR VISIT:

Referred by (if any): _____

What would you like to accomplish out of your time in therapy?

Hobbies/Activities:

CalVCB Authorization Number# _____

VICTIM NAME: _____ **DATE OF CRIME:** _____

CRIME (Explain)

YOUR RELATIONSHIP TO VICTIM: _____

LIVING ARRANGEMENT:

- Rent Own Roommate Homeless Halfway house Shelter Group home
 Mother Father Father & Mother Other: _____

FAMILY HISTORY:

Children? Yes No How many? _____ Live with children Yes No

Name: _____ **Gender** _____ **Age** _____

Mother's Name

Father's Name

Relationship with Mother

Relationship with Father

Close Good Fair Poor Distant

Close Good Fair Poor Distant

Other _____

Other _____

Siblings? Yes No How many sisters _____ How many brothers _____

Name _____ **Gender** _____ **Age** _____ **Relationship with sibling**

Close Good Fair Poor Distant

Close Good Fair Poor Distant

Close Good Fair Poor Distant

Have you ever ran away from home? Yes No How many times? _____ Date of last time _____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

How would you rate your current physical health?

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:

How would you rate your current sleeping habits?

- Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:

How would you rate your current eating habits?

- Poor Unsatisfactory Satisfactory Good Very good

Please list any difficulties you experience with your appetite or eating patterns:

How many times per week do you generally exercise? _____

What types of exercise do you participate in? _____

Are you currently experiencing overwhelming? (If yes, for approximately how long)?

- Sadness _____ Grief _____ Depression _____ Anger _____

Are you currently experiencing any of the following?

- Anxiety Panic attacks Phobias

If yes, when did you begin experiencing this?

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)? Yes No

IF YES, Name of previous Therapist/Practitioner: _____

Last date of appointment: _____

How long were you in therapy? Months _____ Years _____ Weeks _____ Days _____

Are you currently taking any prescription medication? Yes No

List Medications/Dosage:

_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you currently taking any psychiatric medication? Yes No

List Medications/Dosage:

_____	_____	_____
_____	_____	_____

Have you ever been hospitalized? Yes No

Reason for Hospitalization:

If yes, date of last hospitalization: _____ Number of times hospitalized: _____

Have you ever attempted suicide? Yes No (If yes, how many times) _____

When? _____

If yes, do you feel that way now? Yes No

Do you drink alcohol? Yes No (If yes how many times a week?) _____

Do you use drugs? (Marijuana etc.) Yes No (If yes how many times a week?) _____

Do you misuse prescription medication? Yes No (If yes how many times a week?) _____

Are you addicted to Alcohol or Drugs? Yes No Alcohol Drugs

DRUGS & ALCOHOL:

Drug of Choice: _____

Amount: _____

Frequency: _____

Duration: _____

Do you attend AA or NA? Yes No (if yes which one) _____ Frequency _____

Do you have a sponsor? Yes No

Do you have a Support Groups? Yes No (What kind) _____

Do you have any problems with the following?

HIV/Aids High Blood Pressure Diabetic Seizures Asthma Allergies

Cancer Heart problems Polo Cerebral Palsy Hepatitis Headache

Nightmares Sweats Problems with Weight Panic attack Shortness of breath

Hear voices Have visions

Other:

FEMALES ONLY:

Are you pregnant? Yes No Due Date? _____

Have you had any Abortions? Yes No
(Number of terminations) _____ Date of last termination _____

Skin conditions? Yes No

List what kind: _____

WORK HISTORY:

Are you currently employed? Yes No (If no please put source of income) _____

Length of employment: _____

Place of Employment:	Job title:	Monthly Income
_____	_____	\$ _____

Source of Income: _____	\$ _____
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Monthly Household income: \$ _____

Do you enjoy your work? Yes No

Is there anything stressful about your current work? (Please list)

Religious Belief: _____

LEGAL ISSUES: Yes No **(IF YES PLEASE EXPLAIN)**

FAMILY HISTORY:

Family History of Mental Illness:

- Spouse Children Mother Father Siblings Grandmother
 Grandfather Aunt Uncle Other _____

If any checked above, describe illness (give diagnosis if known):

Alcohol or Drug addiction Yes No **(Please indicate whom in your family)**

- _____ Alcohol Drugs _____ Alcohol Drugs
_____ Alcohol Drugs _____ Alcohol Drugs
_____ Alcohol Drugs _____ Alcohol Drugs

What do you consider to be some of your strengths?

What do you consider to be some of your weakness?

SUPPORT SYSTEMS:

Client or Guardian's Signature

Date

IN CASE OF EMERGENCY CONTACT:

Person to contact:

Name:

Address:

City **State** **Zip**

Phone

Relationship

I _____ give permission for **Althea Lee, LMFT**
(Therapist) to contact the above person in the event of an emergency:

Client's Signature

Date