Mindful Solutions NJ, LLC

Intake Form

The information requested on this form is intended to be helpful to you and your therapist in the provision of the best possible services to you. If there is any question that you would prefer not to answer, please feel free to leave blank and discuss in session.

FULL NAME_____Name you prefer to be called_____

Presenting Problem

1. What is/are the reason(s) you are seeking therapy today? _____

_____

_____

2. Did a specific event lead to this report for services? □ Yes □ No If yes, please describe the incident. _____

_____

_____

3. Please describe what you hope to accomplish in this therapy or what you hope will be different in your life as a result of attending therapy. _____

_____

_____

4. How long has the problem been present? _____

5. What solutions to the problem have you tried, and what were the results? _____

_____

_____

6. How much does this problem affect your life? (*Please circle the number that best applies*)

	Not at all	**A little bit**	**A lot**	**All the time**
1. Personally	0	1 2 3	4 5 6 7	8 9 10
2. Family life	0	1 2 3	4 5 6 7	8 9 10
3. Socially	0	1 2 3	4 5 6 7	8 9 10
4. Work-wise	0	1 2 3	4 5 6 7	8 9 10

7. How were you referred to this service? (*Please circle*)

8. Do you make use of an community-based support groups (e.g. 12-Step Programs, social support groups, etc)? □ Yes □ No If yes, please specify: _____

9. Do you have an involvement with any of the following people or services? □ Yes □ No If yes, please circle all that apply:

County Social Worker Probation Officer Adult/Child Protection Guardian Ad Litum Worker's Compensation

If so, please describe. _____

Symptoms

10. Please look these items over and circle the number that best describes how these symptoms have bothered you **recently.**

	Not at all	Mildly	Moderately	Severely
1. Depressed	0	1 2 3	4 5 6 7	8 9 10
2. Guilty feelings	0	1 2 3	4 5 6 7	8 9 10
3. Suicidal thoughts, plans, or attempts Have you ***ever*** thought about, planned or attempted suicide? Thought about Y N Planned Y N Attempted Y N If yes to any of these, when was this? _____	0	1 2 3	4 5 6 7	8 9 10
4. Changed sleep patterns □ Difficulty falling asleep □ Difficulty staying asleep □ Can't get up in a.m. □ Nightmares	0	1 2 3	4 5 6 7	8 9 10
5. Change in weight or eating habits □ Increase □ Decrease	0	1 2 3	4 5 6 7	8 9 10
6. History of restrictive eating, dieting or purging	0	1 2 3	4 5 6 7	8 9 10
7. Insecurity or inferiority	0	1 2 3	4 5 6 7	8 9 10
8. Loss of interest or energy in pleasurable activities	0	1 2 3	4 5 6 7	8 9 10
9. Anxious, nervous, or panicky feelings	0	1 2 3	4 5 6 7	8 9 10
10. Avoiding places or situations	0	1 2 3	4 5 6 7	8 9 10
11. Repetitive thoughts or behaviors	0	1 2 3	4 5 6 7	8 9 10
12. Change in work habits □ Increase □ Decrease	0	1 2 3	4 5 6 7	8 9 10
13. Change in spending habits □ Increase □ Decrease	0	1 2 3	4 5 6 7	8 9 10
14. Anger or temper problems	0	1 2 3	4 5 6 7	8 9 10
15. Flashbacks or intrusive memories	0	1 2 3	4 5 6 7	8 9 10
16. Physical problems, pain, or illness	0	1 2 3	4 5 6 7	8 9 10
17. Sexual worries or problems	0	1 2 3	4 5 6 7	8 9 10
18. Brain fog, fuzzy thinking or dissociation	0	1 2 3	4 5 6 7	8 9 10
19. Memory problems	0	1 2 3	4 5 6 7	8 9 10
20. Confused or disorganized thoughts	0	1 2 3	4 5 6 7	8 9 10
21. Periods of high energy/activity with less need to sleep	0	1 2 3	4 5 6 7	8 9 10

11. Do any of the following concerns contribute to your symptoms(s)? (*check all that apply*)

___ Family move to a new home
___ Birth of a child or sibling
___ Fighting with spouse
___ Post-divorce adjustment
___ Financial stress
___ Marital unfaithfulness
___ Parenting problems
___ Spiritual problems
___ Death of a family member
___ Adjustment to new job
___ Adjustment to school
___ Law violations
___ Dishonesty
___ Career concerns/unemployment
___ Empty nest
___ Previous therapy
___ Development problems
___ Suspect physical/sexual abuse
___ Known physical/sexual abuse
___ Alcohol/Substance abuse
___ Compulsive gambling/spending
___ Pornography use
___ Anger/Violence
___ Other _____

Mental Health & Medical History

12. Who is your primary care physician and your primary clinic? _____

_____

13. Who else do you regularly see as part of your routine health care? _____

14. List any significant health problems, past or present, including surgeries and/or illnesses with the ***corresponding dates.***

_____

_____

_____

15. Are you currently taking any medications? □ Yes □ No If yes, please list:

Medication	Dose and number of pills you take per day	Prescribing doctor

16. Have you ever taken any medications for depression, anxiety, or mental health issues? □ Yes □ No If yes, please list:

Medication Name	Prescribed for? (eg: depression, anxiety)	When (approx.)	How long were you on the medication?	Prescribing doctor

17. Do you have any allergies to medications? □ Yes □ No If yes, please list and describe the reaction. _____

_____

18. List other therapy or counseling you have received in the past or are receiving now:

Therapist's name	Address	Approximate dates

19. If you think it would be helpful for your therapist to contact a previous therapist or physician, you will need to sign a Release of Information form. To receive a Release of Information form, please check here □ .

20. Have you ever been hospitalized for mental or nervous problems? Yes No If yes, when and where? _____

_____

_____

Substance Use

21. Please describe your use of the following substances:

	Daily	Weekly	Occasionally	In the past but not now	Not at all
Caffeine					
Tobacco					
Alcohol					
Prescription drugs					
Inhalants					
Street drugs					
Over-the-counter medications					
Other: _____					

22. Have you ever experienced any of the following as a result of substance use?

□ Blackouts □ Bad reactions □ Withdrawal symptoms □ Overdose □ DUI □ Other: _____

Please give details _____

_____

23. Have you ever felt you should **cut down** on your drinking or drug use? □ Yes □ No

24. Have people **annoyed** you by criticizing your drinking or drug use? □ Yes □ No

25. Have you ever felt bad or **guilty** about your drinking or drug use? □ Yes □ No

26. Have you ever had a drink or used drugs as an **eye-opener** first thing in the morning to steady your nerves, get rid of a hangover, or to get the day started? □ Yes □ No

27. Have you ever had treatment for any type of alcohol or substance use? □ Yes □ No If yes, when? _____

Please describe: (include inpatient, outpatient, detox): _____

_____

Resources

28. What has helped you manage or endure your current problem? _____

_____

29. Please describe the people in your life that currently play a supportive, influential, or friendship role. _____

_____

30. What interests or passions give you meaning to your life? _____

_____

31. Do you have any spiritual beliefs or practices that are important to you? □ Yes □ No If yes, please explain: _____

32. What aspects of your culture, heritage, or ethnicity would you like your therapist to be aware of? _____

_____

Family Information

33. Please list those who you consider part of your immediate family and/or your current household.

Name	Age	Relation to you	Living with you?
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

Other

34. Is there anything else that you would like your therapist to know and that you have not written about on any of these forms?

☐ Yes ☐ No If yes, please tell me about it here or on another paper: _____

_____

_____

Signature and Date

I acknowledge that the information on this form is accurate to the best of my knowledge, and that I will inform my therapist of any changes in my personal circumstances including address, symptoms experienced, suicidal thoughts and substance use.

Client Signature _____ Date _____