BODY/MIND SYNTHESIS NEW CLIENT INTAKE FORM

(Please complete all information on this form and bring to your first visit)

Name:_____ Date:_____
Address (with zip code):_____
Phone (Cell):_____(H):_____(W):_____
Person to notify in case of emergency: Name/Relationship:_____(Cell:)_____

How did you find BodyMind Synthesis? (Who referred you?)_____

What are the main problems which you are seeking help for?
1)_____
2)_____
3)_____

Please list current medical conditions or mental health diagnosis or conditions:_____
_____
_____
Are you taking any prescription medications for physical or emotional health? If so please list them and what they are for:_____
_____
List other significant medical problems, or emotional traumas from the past, indicating when they occurred:_____
_____

Symptom Checklist: (indicate 1 for current symptoms that are mild, 2 for moderate and more frequent, 3 for severe or frequent, X if in the past, underline the ones that are most problematic for you at this time.)

( ) Depressed mood	( ) Racing thoughts	( ) Feeling unloved
( ) Unable to enjoy activities.	( ) Impulsivity	( ) Avoidance
( ) Sleep disturbance	( ) Increased libido	( ) Shame
( ) Forgetfulness	( ) Increased addictive behavior	( ) Obsessive compulsive
( ) Change in appetite	( ) Increased irritability/anger	( ) Lethargic
( ) Excessive guilt	( ) Crying spells	( ) Hopeless/ Despairing
( ) Fatigue	( ) Excessive worry	( ) Isolated/ Lonely
( ) Decreased libido	( ) Anxiety	( ) Abandoned/ Rejected

Substance Abuse:

Have you ever been treated for alcohol or drug use or abuse? If yes, for which substances, where and when:_____
Do you currently use alcohol or drugs? If so, which ones, how many days per week and how much per time?_____
_____
Do you feel you need to cut down on your drinking or drug use? If so how is it interfering in your life, work, productivity or health?_____
_____
Are you interested in getting help for your drinking or drug use?_____

Suicide Risk Assessment:

Have you ever had any feelings or thoughts that you didn't want to live?_____
If yes, please indicate when and how often you had/have those thoughts, and whether recently or in the past:_____
If yes, indicate if you had or have a plan and/or method:_____
If yes, indicate if you ever have attempted to harm yourself in the past:_____
Have you had any psychiatric hospitalizations in the past and if so, when and for what:_____

Are you currently in treatment for any emotional or physical symptoms? If so, for what, how long and with who? (list name of therapist, medical or integrative health care provider)_____
_____
_____
What are the main physical symptoms you are dealing with currently?_____
_____
Please list other health care practitioners you see and their specialty:_____
_____

Relationship History, Occupational History and Current Family:

Describe any family problems, alcohol or drug abuse, or sexual or emotional abuse in your family of origin:_____

Are you single, married, partnered, divorced, or widowed, and for how long?_____
Are you satisfied or unsatisfied in your relationship? Why or why not?_____
_____
Do you feel emotionally and physically safe in your relationship? Why or why not?_____
_____
Do you have children? If so, list their ages and gender:_____
_____
Describe your relationship with your children: _____
_____
List everyone who currently lives with you:_____
_____
Are you working, student, unemployed, disabled or retired and for how long?_____
If you are currently working, what is your occupation and how long have you been in it?_____
_____
Are you happy with your current employment? Why or why not?_____
_____
What do you do for self-care and how often? (indicate your level of exercise, sleep, social connection, spiritual practices, or other self-care)_____
_____
Do you have a support system who reinforces your self-care? If so, who or what?_____
_____
Do you believe you can improve your life? If so, how would you like to improve it?_____
_____
What would you like to achieve in your work with Nancy, either short term or long term to improve your health or life?_____
_____

Signature:_____Date:_____