Life Transformations Therapy
19560 Club House Rd.
Montgomery Village, MD 20886

New Client Intake Form

Name: ______________________________________

Address: ___________________________________ **Phone: Cell** ____________OK to leave message?
___________________________________ **Home** ________________ OK to leave message?
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E-mail: ____________________________________ __________________________________

Who were you referred by? ____

If you were self-referred, how did you find me? _____________________________________

Gender: **M F** **Date of Birth:** ____________ **Marital Status:** **Married Single Widow Divorced Separated**

Account Information (who will be responsible for account charges)

Responsible Person's Name:____

Address:____

City___________________________ State_________ Zip_____________________

Home Phone_______________ Work Phone_________________ Cell______________

Date of Birth_____________________ SSN__________________________________

Relationship to Client____

Place of Employment____

Employer's Address____

City__________________ State______ Zip_______________________

How long have you worked here___________________

Insurance Information

Primary Insurance:

Insurance Company____

Policy Holder's Name_________________________ DOB____________ SSN___________

Address______________________________ City____________ State_______ Zip_______

Policy #______________________ Group Name or #________________________________

Insurance Phone # ____________________________

Secondary Insurance:

Insurance Company____

Policy Holder's Name____________________________ DOB____________ SSN___________

Address__________________________________ City_____________ State_______ Zip_______

Policy #_________________________ Group Name or #___________________________________

Insurance Phone # ______________________________________

General description of what brings you to therapy: ____

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I am currently experiencing (check all that apply): Depression ___ Sadness ___ Anxiety ___ Grief ___ Loneliness ___ Anger ___Lack of Motivation ___ Difficulty in Relationships ___ Work-related Issues ___ Alcohol or Drug Issue ___ Problems with Sleep ___ Problems with Eating ___ Sexuality Issues ___ School-related Issues ___ Medical Issues ___ Suicidal Thoughts ___ Other ___________________________________ Other _______________________ Other ___________________________ Other _______________________________

Have you ever seen a therapist before? Y N
If yes, when and what for:

Have you ever been prescribed medications for mental health issues? Y N
If yes, when and what did you take:

List all current medications with doses:

Have you been hospitalized before? If yes, when/where and for what condition?

Have you ever attempted suicide or self-harm?

Do you have any current health or medical issues?

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History of Abuse – Emotional, Verbal, Sexual?

Legal History, If Any:

Divorce/Custody Issues?

List Names and Ages of Any Children:

Have you ever been treated for substance abuse? Y N
If yes, when and what for:

Family History of Substance or Mental Health Issues?

Employment/School:

Family of Origin/Who Raised You?

Parent(s):

Siblings:

Other Significant Family Members:

Hobbies/Interests:

Spiritual Orientation, If Any:

Goals for Therapy:

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Mental Status Examination:

Appearance/Attitude:
Behavior:
Mood/Affect:
Speech:
Perception (including hallucinations):
Thought Process:
Thought Content (include delusions & suicidal/homicidal ideation):
Orientation/Memory:
Attention/Concentration:
Abstract Thought:
Information/Intelligence:
Judgment/Insight:

Diagnostic Impression:
Axis I:
Axis II: 799.9
Axis III:
Axis IV:
GAF =

Treatment Plan:

Signature of Therapist:
Date: