Skylar Strait, M.Ed., LPC

CLIENT INTAKE FORM

Please provide the following information for our records. Leave blank any question you would rather not answer. Information you provide here is held to the same standards of confidentiality as our therapy. Please print out this form and bring it to your first session.

Name: _____
(Last) (First) (Middle Initial)

Name of parent/guardian (if you are a minor):
_____
(Last) (First) (Middle Initial)

Birth Date: _____ /_____/_____ Age: _____ Gender: □ Male □ Female

Ethnicity: _____ Social Security Number: _____-_____-_____

Marital Status:
□ Never Married □ Partnered □ Married □ Separated
□ Divorced □ Widowed

Number of Children: _____

Local Address: _____
(Street and Number)

_____
(City) (State) (Zip)

Home Phone: ( ) _____ May we leave a message? □ Yes □ No

Cell/Other Phone: ( ) _____May we leave a message? □ Yes □ No

E-mail: _____
May we email you? □ Yes □ No
*Please be aware that email might not be confidential.

Referred by:
_____

8008 Slide Rd., Suite 24, Lubbock, TX 79424 | (806) 340-0446 | skylarmstrait@gmail.com

Are you currently receiving psychiatric services, professional counseling or psychotherapy elsewhere? □ Yes □ No

Have you had previous psychotherapy/counseling?
□No □Yes, at Previous therapist's name

_____

Are you currently taking prescribed psychiatric medication (antidepressants or others)? □No □Yes If Yes, please list:

_____

If no, have you been previously prescribed psychiatric medication?
□No □Yes If Yes, please list:

_____

HEALTH AND SOCIAL INFORMATION

1. How is your physical health at present? (please circle)
Poor Unsatisfactory Satisfactory Good Very good

2. Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.):

_____

3. Are you having any problems with your sleep habits? □ No □ Yes
If yes, check where applicable:
□ Sleeping too little □ Sleeping too much □ Poor quality sleep □ Disturbing dreams
□ Other _____

4. How many times per week do you exercise? _____
Approximately how long each time? _____

5. Are you having any difficulty with appetite or eating habits? □ No □ Yes
If yes, check where applicable:
□ Eating less □ Eating more □ Binging □ Restricting

6. Have you experienced significant weight change in the last 2 months?
□ No □ Yes

7. Do you regularly use alcohol? □ No □ Yes
In a typical month, how often do you have 4 or more drinks in a 24-hour period?

_____

8. How often do you engage in recreational drug use?
□ Daily □ Weekly □ Monthly □ Rarely □ Never

9. Have you had suicidal thoughts recently?
□ Frequently □ Sometimes □ Rarely □ Never

Have you had them in the past?
□ Frequently □ Sometimes □ Rarely □ Never

10. Are you currently in a romantic relationship? □ No □ Yes
If yes, how long have you been in this relationship? _____
On a scale of 1-10, how would you rate the quality of your current relationship? ____

11. In the last year, have you experienced any significant life changes or stressors:

_____

Have you ever experienced:
Extreme depressed mood: □ No □ Yes
Wild Mood Swings: □ No □ Yes
Rapid Speech: □ No □ Yes
Extreme Anxiety: □ No □ Yes
Panic Attacks: □ No □ Yes
Phobias: □ No □ Yes
Sleep Disturbances: □ No □ Yes
Hallucinations: □ No □ Yes
Unexplained losses of time: □ No □ Yes
Unexplained memory lapses: □ No □ Yes
Alcohol/Substance Abuse: □ No □ Yes
Frequent Body Complaints: □ No □ Yes
Eating Disorder: □ No □ Yes
Body Image Problems: □ No □ Yes
Repetitive Thoughts (e.g., Obsessions) : □ No □ Yes
Repetitive Behaviors (e.g., Frequent Checking/Washing Hands): □ No □ Yes
Homicidal Thoughts: □ No □ Yes
Suicide Attempt: □ No □ Yes

OCCUPATIONAL INFORMATION:
Are you currently employed? □ No □ Yes
If yes, who is your current employer/position?

_____

If yes, are you happy at your current position?

_____

Please list any work-related stressors, if any:

_____

RELIGIOUS/SPIRITUAL INFORMATION:
Do you consider yourself to be religious? □ No □ Yes
If yes, what is your faith?

_____

If no, do you consider yourself to be spiritual? □ No □ Yes

FAMILY MENTAL HEALTH HISTORY:
Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (circle any that apply and list family member, e.g., Sibling, Parent, Uncle, etc.):

Difficulty	**Family Member**
Depression: □ No □ Yes	_____
Bipolar Disorder: □ No □ Yes	_____
Anxiety Disorders: □ No □ Yes	_____
Panic Attacks: □ No □ Yes	_____
Schizophrenia: □ No □ Yes	_____
Alcohol/Substance Abuse: □ No □ Yes	_____
Eating Disorders: □ No □ Yes	_____
Learning Disabilities: □ No □ Yes	_____
Trauma History: □ No □ Yes	_____
Suicide Attempts: □ No □ Yes	_____
Personality Disorder: □ No □ Yes	_____
If yes, which one?	_____

OTHER INFORMATION:

What do you consider to be your strengths?

What do you like most about yourself?

What are effective coping strategies that you've learned?

What are your goals for therapy?

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