**Cristina Lima Therapy**
Individual, Couples, and Family
281-770-1779

**INTAKE FORM**

Please provide the following information which is considered to be protected as confidential information.

Client's Name: Today's Date:

Date of Birth: Age: Gender: Race:

Parent / Guardian (if minor):

Address:

Cell Phone: ok to leave message? ◯ Yes ◯ No

Other Phone: ok to leave message? ◯ Yes ◯ No

Email: ok to send message? ◯ Yes ◯ No

What is the main reason for you to seek therapy?

Have you ever received any type of mental health care (psychotherapy, psychiatric services, etc.)? With whom? When? For how long?

Are you currently taking any prescription/psychiatric medications? Please list.

Have you experienced life changes or stressful events recently? Please describe.

Are you currently experiencing overwhelming sadness, grief, or depression? Please describe.

Are you currently experiencing anxiety, panic attacks, or have any phobias? Please describe.

Do you drink alcohol more than once a week? How much? How often?

Do you use/abuse recreational/prescription drugs? What drugs?

Do you exercise? How? How frequently?

Are you married or in a relationship? ◯ Yes ◯ No How long?
Do you have children with current partner? ◯ Yes ◯ No How many?
List age and gender of children:

Have you been married before? ◯ Yes ◯ No
Do you have children from previous relationship? ◯ Yes ◯ No How many?
List age and gender of children:

Are you having relationship problems? Please describe.

What is your occupation?
Are you experiencing work/school problems? Please describe.

Are you required by a court or probation officer to seek counseling at this time? Please describe.

Are you currently/recently involved in any court proceeding? Please describe.

Do you consider yourself to be spiritual or religious? What is your religion or type of faith?

Are you experiencing religious or spiritual problems? Please describe.

Please indicate and describe any specific issues you are currently experiencing in the following areas.

- ☐ Physical health:
- ☐ Sleeping habits:
- ☐ Eating patterns:
- ☐ Chronic pain:

Please describe the configuration of your family of origin.

Please describe significant childhood and/or adolescent experiences.

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Please identify if there is a family history of any of the following. Indicate the family member's relationship to you.

| | |
|---|---|
| ☐ Depression | Relationship: |
| ☐ Anxiety | Relationship: |
| ☐ Alcohol/Substance abuse | Relationship: |
| ☐ Domestic violence | Relationship: |
| ☐ Eating disorders | Relationship: |
| ☐ Obesity | Relationship: |
| ☐ Obsessive-compulsive behavior | Relationship: |
| ☐ Schizophrenia | Relationship: |
| ☐ Suicide/suicide attempts | Relationship: |

Please indicate which of the following applies to you.

- ☐ I am having thoughts of harming or killing myself.
- ☐ I have a plan of how I would harm or kill myself.
- ☐ In the past I have wished for death or considered suicide.
- ☐ I have harmed myself or attempted suicide in the past.
- ☐ None of these apply to me.

Please indicate which of the following applies to you.

- ☐ I am having thoughts of physically harming or killing another person.
- ☐ I have a plan of how I would hurt that person.
- ☐ In the past, I have caused physical harm to another person.
- ☐ None of these apply to me.

What would you like to accomplish through therapy?