CLIENT INTAKE

Jonathan R. Aronoff, PhD
36 Main Street
Stockbridge, MA 01262

Client Name:

Date of first appointment:

Please take your time in providing the following information. The questions are designed to help me begin to understand you so that our time together can be as productive as possible. All information provided is confidential.

Referred by:

- ☐ Medical Provider: ______________________________________
- ☐ Insurance Provider: ____________________________________
- ☐ My Website:
- ☐ PsychologyToday
- ☐ Friend/Family: ______________________________________
- ☐ Other: ______________________________________

Have you previously received any type of mental health services?

- ☐ Yes
- ☐ No

If yes, which of the following:

- ☐ Psychotherapy
- ☐ Medication
- ☐ Outpatient Hospitalizations
- ☐ Inpatient Hospitalization

If yes, please provide:

Name of provider or facility:____
Location:____
Dates of treatment:____
Reason for treatment:____

Briefly, what brings you in today

When did your problem first start? Within the last:

- ☐ 30 days
- ☐ 6--12 months
- ☐ 2 years
- ☐ During adolescence
- ☐ During childhood

What areas of your life have been a ected because of this problem?

Are you currently experiencing overwhelming sadness, grief or depression?

- ☐ Yes
- ☐ No

If yes, for approximately how long? ________________________
Are you currently experiencing anxiety, panic attacks or have any phobias?

- ☐ Yes
- ☐ No

If yes, when did you begin experiencing this? ________________________

Please describe any major losses or traumas you have experienced:

What significant life changes or stressful events have you experienced recently?

What would you like to accomplish out of your time in therapy

Childhood & Family History

Where were you born? ____

Where did you grow up? ______________________________________

- ☐ City
- ☐ Suburbs
- ☐ Country

Please list your parents and siblings. Please use additional space on the back if needed

Name	Age	Relationship	Where do they live now?	If deceased, age and cause of death

Who did you live with while growing up? ____

Mother's occupation: ____

Father's occupation? ____

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

Condition	Please circle	List Family Member
Alcohol/Substance Abuse	yes/no	
Anxiety	yes/no	
Depression	yes/no	
Domestic Violence	yes/no	
Sexual Abuse	yes/no	
Eating Disorders	yes/no	
Obesity	yes/no	
Obsessive Compulsive Disorder	yes/no	
Schizophrenia	yes/no	
Suicide Attempts	yes/no	
Other diagnosed mental health condition?	yes/no : which was---	

Marital Status:

- ☐ Never Married
- ☐ Domestic Partner
- ☐ Married
- ☐ Separated
- ☐ Divorced -- For how long?
- ☐ Widowed: Please provide your partners name and year deceased:

If married, how long have you been married for and what is your partners name:

____

On a scale of 1-10 (best), how would you rate your relationship? _________________________

Are you currently in a romantic relationship?

- ☐ Yes -- How long? ________
- ☐ No

On a scale of 1-10 (best), how would you rate your relationship? _________________________

Please list any children, their names, and ages:

Name	Age	Relationship	Name of other parent	If deceased, age and cause of death
			(see next page for Medical History)	

Medical History & Current Health

Please list any medications, herbs, or supplements. Be sure to include the condition, as some medications are prescribed for o -label use. Continue on the back if needed, or provide a separate list. If you have a complicated medical profile, please supply supporting documentation to be able to facilitate a comprehensive understanding of your health.

Medication/Supplement	Dosage	Condition	Date Began/Stopped

Prescribing provider and contact information:

Name: ____

Specialty: ____

Facility: ____

Phone, email, or Fax: ____

Please list any significant past health conditions or hospitalizations:

How would you rate your current physical health?

- ☐ Poor
- ☐ Unsatisfactory
- ☐ Satisfactory
- ☐ Good
- ☐ Very Good

Please list any specific health problems you are currently experiencing:

How would you rate your current sleeping habits?

- ☐ Poor
- ☐ Unsatisfactory
- ☐ Satisfactory
- ☐ Good
- ☐ Very Good

If you are having problems, in which phase of sleep are you experiencing issues?

☐ Falling asleep
☐ Staying asleep
☐ Awakening early
☐ Sleep apnea

Please list any other specific sleep problems you are currently experiencing:

How many times per week do you generally exercise? ____________ What types of exercise do you participate in:

Are you currently experiencing any chronic pain?

☐ No
☐ Yes

If yes, please describe:

Please describe current use of alcohol, cigarettes, and/or recreational drugs:

Please describe previous use of alcohol, cigarettes, and/or recreational drugs:

Educational History

Education	**Completed (Yes/No)**	**Name of School & Degree**	**Dates (e.g., 2002-2004)**
Elementary School			
Middle School			
High School			
Vocational Training			
Associate's Degree			
Bachelor's Degree			
Master's Degree			
Doctoral Degree			

Other			

Employment History

Dates (e.g., 1999-2004)	Employer	Job Title

Assessing Eight Areas of Well-Being

How satisfied are you in each of the following areas of well-being, on a scale from 1 to 10, with 1 = totally dissatisfied and 10 = totally satisfied? How much desire do you have to change each area of well-being, with 1 = no desire and 10 = great desire?

Area of Well-Being	Satisfied (1-10)	Desire to Change (1-10)
1a. Physical Health		
1b. Psychological Health		
2. Career		
3. Social Connections (Relationships)		
4. Home		
5. Community		
6. Time and Money		
7. Time in Nature		
8. Mindfulness or Spirituality		