L.I.F.E.
Lifting Individual & Family Expectations, Inc.
...supporting individuals and empowering families

Intake Form

Please take a moment to complete all information on the intake form. This form may seem long but most of the questions require only a check mark. This form will begin to give your therapist a better understanding of your situation in order to provide the best possible care.

Date: _____

Client Name: _____ **DOB:** _____ **Age:** ____

Gender: ____ Male ____ Female **Race:** _____

Name of parent/guardian if client is under age 18: _____

Address: _____

Home Phone: _____ **May we contact you at home?** ____ Yes ____ No

May we leave a message? ____ Yes ____ No

Cellular Phone: _____ **May we contact your cell phone?** ____ Yes ____ No

May we leave a message? ____ Yes ____ No

E-mail Address: _____ **May I contact you via email?** __ Yes __No

How did you hear about us:

___ Google Search/Internet ___ Doctor ___ Psychiatrist ___ Word of Mouth/Friend ___ Thumbtack

____ Other: _____

What are the problem(s) for which you are seeking help?

☐	Physical Aggression	☐	Tantrums	☐	Arguing	☐	Noncompliant
☐	Disruptive	☐	Anti-social (stealing, breaking rules…)	☐	School Problems	☐	Lying
☐	Work problems	☐	Anger	☐	Conflict with others	☐	Blames Others
☐	Sleeping Problems	☐	Eating Problems	☐	Low Self-Esteem	☐	Depression
☐	Anxiety	☐	Irritable	☐	Sexually Inappropriate	☐	Legal Problems
☐	Somatic Complaints	☐	Suicidal/Homicidal	☐	Hyperactive	☐	Impulsive
☐	Alcohol/Drug Use	☐	Trauma Victim	☐	Psychotic	☐	Marital / Relationship
☐	Foster Care Placement	Other:					

When did the problems begin?

What would you like to see change as a result of treatment?

Client's Strengths	Client's Weaknesses/Challenges

Marital Status:

_____ Never Married ___ Domestic Partner ___ Married ___ Separated ___ Divorced ___Widowed
Number of Marriages ____

Family Relationships:

Does the client have any children? ☐ None Reported

Name	Age	Date of Birth	Sex	Custody? Y/N	Lives With?	Additional Information

Who else lives with the client? (Include spouses, partners, siblings, parents, other relatives, friends)

☐ None Reported

Name	Age	Sex	Relationship	Additional Information

Primary language of household/family:	**Secondary:**

Client Education:

Educational Level (select one): ☐ less than 12 years – enter grade completed		☐ Some college or tech school
☐ Unknown	☐ High School Grad/GED	☐ College Graduate
If still attending, current School/Grade:		
Vocational School/Skill Area:		
College/Graduate School – Years Completed/Major:		

Family History:

Family History of (select all that apply): ☐ **None Reported**						
	Mother	**Father**	**Siblings**	**Aunt**	**Uncle**	**Grandparents**
Alcohol/Substance Abuse	☐	☐	☐	☐	☐	☐
History of Contemplating Suicide	☐	☐	☐	☐	☐	☐
History of Mental Illness such as:	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐
Schizophrenia	☐	☐	☐	☐	☐	☐
Bipolar Disorder	☐	☐	☐	☐	☐	☐
Alzheimer's	☐	☐	☐	☐	☐	☐
Anxiety	☐	☐	☐	☐	☐	☐
Attention Deficit/Hyperactivity	☐	☐	☐	☐	☐	☐
Learning Disorders	☐	☐	☐	☐	☐	☐
School Behavior Problems	☐	☐	☐	☐	☐	☐
Incarceration	☐	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☐
Comments:						

Family History of Psychiatric, Mental Health & Substance Abuse Treatment History:
☐ **None Reported**

Who?	**Outpatient Treatment Location:**	**Date:**	**What was the result of treatment?**	**Medication**
	Residential Treatment:	**Date:**	**What was the result of treatment?**	**Medication**

Client Medical History: ☐ **None Reported**

Allergies (Medication & Other):		
Current Medical Conditions:		
Current Medications (include herbs, vitamins, & over-the-counter):		
Rx Name	**Dosage**	**Frequency**
Rx Name	**Dosage**	**Frequency**
Rx Name	**Dosage**	**Frequency**

Past Medications: ☐ **None Reported**		
Rx Name	**Dosage**	**Frequency**
Rx Name	**Dosage**	**Frequency**
Rx Name	**Dosage**	**Frequency**
Past Medical History:		

(hospitalizations/residential treatment - list all prior inpatient or outpatient treatment including RTC, group home, therapeutic foster care, aftercare, inpatient psychiatric, outpatient counseling): ☐ **None Reported**

Dates	Inpt/Outpt	Location	Reason	Completed? Y/N

Surgeries:

Client Behavioral Assessment:

Abuse/Addiction – Chemical & Behavioral ☐ None Reported

Drug	Age First Used	Age Last Used	Recent Pattern of Use (frequency & Amount, etc)	Date Last Used
Alcohol				
Cannabis				

Cocaine				
Stimulants (crystal, speed, amphetamines, etc)				
Methamphetamine				
Inhalants (gas, paint, glue, etc)				
Hallucinogens (LSD, PCP, mushrooms, etc)				
Opioids (heroin, narcotics, methadone, etc)				
Sedative/Hypnotics (Valium, Phenobarb, etc)				
Designer Drugs/Other (herbal, Steroids, cough syrup, etc)				
Tobacco (smoke, chew)				
Caffeine				
Ever injected Drugs? ☐ Yes ☐ No			**If Yes, Which ones?**	
Drug of Choice?				

Client Psychiatric/ Mental Health & Substance Abuse Treatment History:

Outpatient Treatment Location:	**Date:**	**What was the result of treatment?**	**Medication**
Residential Treatment:	**Date:**	**What was the result of treatment?**	**Medication**

Client Bereavement/Loss, Spiritual & Cultural:

Please list significant losses, deaths, abandonments, traumatic incidents:
Spiritual/Cultural Awareness & Practice
What are your biological family's traditions, spirituality or religion?
What are your adoptive/foster family's traditions, spirituality or religion? ☐ None Reported
What are your traditions, spirituality or religion?
Would client like a spiritual advisor? ☐Yes ☐No Comment:

Client Abuse/Neglect/Exploitation Assessment:

History of neglect (emotional, nutritional, medical, educational) or exploitation? ☐Yes ☐No **If yes, please explain:**

Was it reported? ☐ **Yes** ☐ **No**	**To whom?**
Outcome	
Has client ever witnessed abuse or family violence? ☐ No ☐ Yes, explain:	

Client Risk Assessment:

Have you ever had feelings or thoughts that you didn't want to live? ☐ **Yes** ☐ **No** If yes, please describe.

When was the last time you had thoughts of dying? _____

Do you currently feel that you don't want to live? ☐ Yes ☐ No

Do you feel hopeless and/or worthless? ☐ Yes ☐ No

Have you ever thought about or tried to harm another person or animals? ☐ Yes ☐ No

Is there a handgun in the home? ☐ Yes ☐ No

Any other weapons? ☐ Yes ☐ No

Employment: Currently Employed?			
☐ Yes	Employer	Length of Employment	
☐ Satisfied	☐ Dissatisfied	☐ Supervisor Conflict	☐ Co-worker Conflict
☐ No	Reason:		

Client Legal Status Screening:

Past or current legal problems (select all that apply)?		
☐ None	☐ Gangs	☐ DUI/DWI
☐ Arrests	☐ Conviction	☐ Detention
☐ Jail	☐ Probation	☐ Other:
If yes to any of the above, please explain:		

_____ _____ _____

Client Printed Name **Client Signature** **Date**

_____ _____ _____ _____

LPHA Name **LPHA Signature** **Credentials** **Date**