Blakely Patterson, LMFT

2021 21st Avenue South, Suite #426
Nashville, TN 37212
615-631-4279

Client Intake Form

Name: _____ Age:____ DOB:_____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____ Email: _____

Emergency Contact (Name/Phone): _____

How did you find me? _____

Have you ever been in counseling before? ___Yes ___No

If so, for what reason? _____

Was it helpful? ___Yes ___No Counselor's Name: _____

Occupation: _____ Years: _____

Place of Employment: _____

How much do you enjoy your work? _____

Highest Level of Education: _____

Primary Care Physician: _____

Date of last full examination: _____

List any significant medical problems: _____

_____

List any currently prescribed medications (and reason for taking):

_____

_____

_____

_____

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Have you ever had what one might consider a "nervous breakdown?"

___Yes (When?) _____No_____

List any hospitalizations for emotional or psychological issues:

Are you aware of mental illness in your family history? _____

_____

_____

Have you ever considered suicide? ___Yes ___No

Have you ever attempted suicide? ___Yes ___No

Are you currently having any suicidal thoughts? ___Yes ___No

Do you currently use any of the following substances?

Alcohol ___Yes ___No If yes, how much/day? _____

Cigarettes ___Yes ___No If yes, how much/day? _____

Other chemical substances (marijuana, cocaine, herbs, etc): _____

_____ If so, how much/day? _____

Caffeine: ___Yes ___No If yes, how much/day? _____

How much sleep do you routinely get each night? _____

Do you have any sexual concerns? ___Yes ___No

If yes, please describe: _____

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Present Relationship Status: (Check one)

___Single ___Married (# of years) ___ ___Divorced (# of years?) ____

___Separated (how long?) ___ ___Widowed (how long?) _____

Briefly describe your current relationship (if applicable): _____

Past and Present Spouse/Partner Information:
Names: Ages: # of Years together: Occupation:

Children:

Names: Ages: Name of Co-parent:

Your Parents:
Names: Ages: Marital Status: Deceased?

Briefly describe your relationship with each parent: _____

_____

_____

Siblings:

Names: Ages: Marital Status: Occupation:

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Do you have a religious affiliation? _____ If so, describe: _____

How important is a spiritual perspective to you in doing therapy?
_____

For what areas of your life are you seeking assistance?
(ie – marital, relationship, family, work, grief, depression, etc)

1. _____
2. _____
3. _____

Briefly describe what you hope to accomplish with counseling.
_____
_____
_____
_____

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Please Mark All Symptoms That Apply

__Depressed Mood
__Lost interest in most Activities
__Increased appetite
__Decreased appetite
__ Weight Gain
__ Weight Loss
__ Difficulty going to sleep
__Difficulty staying asleep
__ Fatigue, loss of energy
__ Feelings of worthlessness
__ inappropriate guilt
__ Difficulty concentrating
__ Preoccupation with death
__Suicidal thoughts
__Excessive or uncontrollable worry
__Restlessness
__Irritable
__Decreased need for sleep
__Increased talking
__Racing thoughts
__Distractible
__Elevated mood
__Engaging in risky, pleasurable activities
__Mood swings
__Feelings of panic
__Pounding heart, chest pains, shaking
__Shortness of breath, dizziness, sweating
__Recurrent undesirable thoughts
__Repetitive behaviors (hand washing, checking) or
__Mental acts (counting etc)
__Nausea or abdominal stress
__Fear of losing control
__Fear of dying
__Recurrent Intrusive Memories
__Flashbacks
__Efforts to avoid memories
__Fear of social situations
__Alcohol Problems
__Drug use problems
__Compulsive Dieting
__Vomiting, use of laxatives
__Marital Problems
__Sexual Problems
__Impulsive
__Overwhelmed
__Easily upset, on edge
__Angry
__Careless, forgetful, easily distracted
__Difficulty organizing, loses things