UNIFY BEHAVIORAL HEALTH
Personalized Counseling

Client Intake Questionnaire

Please fill in the information below and bring it with you to your first session. Please note: information provided on this form is protected as confidential information.

Personal Information:

Name:_____ Date: _____

Parent/Legal Guardian (if under 18): _____

Address: _____

Home Phone: _____ May we leave a message/text? ☐ Yes ☐ No

Cell/Work/Other Phone: _____ May we leave a message/text? ☐ Yes ☐ No

Email: _____ May we leave a message? ☐ Yes ☐ No

**Please note: Email correspondence is not considered to be a confidential medium of communication.*

DOB: _____ Age: _____ Gender: _____

Marital Status: □ Never Married □ Domestic Partnership □ Married □ Separated □ Divorced

□ Widowed

Veteran Status: □ Never Served □ Active Duty □ Retired □ Recently Separated □ Veteran

Referred By (if any): _____

Emergency contact _____ Relationship to you: _____

Cell/Work/Other Phone: _____ Email: _____

Insurance Information

Primary Insurance Company: _____ ID Policy #: _____

Group #:_____ Claims Address: _____

Phone #: _____-_____-_____

Policy holder's Name: _____

Date of Birth:_____ Social Security #: _____

Effective Date of Insurance: _____

Policy Holder's Employer: _____ Phone #: _____- _____-_____

State Zip Code
Other Phone #: _____-_____-_____ Sex: Male Female

Social Security Number: _____-_____-_____

Patient Relationship to Insured: _____

Person Responsible for Account: _____

Name (if different from patient): _____

Date of Birth: ____/_____/_____ Phone # _____-_____-_____

AUTHORIZATION TO BILL INSURANCE:

Patient or Authorized person's signature: I authorize Unify Behavioral Health LLC to submit claims on my behalf. I authorize the release of any medical or other information necessary to process my claims.

Signed _____ Date_____

Client History

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

□ No □ Yes, previous therapist/practitioner: _____

Are you currently taking any prescription medication? □ Yes □ No
If yes, please list:

_____
_____

Have you ever been prescribed psychiatric medication? □ Yes □ No
If yes, please list and provide dates:

_____
_____

Have you ever had thoughts of self-harm/suicidal ideation? _____

General and Mental Health Information

1. How would you rate your current physical health? (Please circle one) Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing: _____
_____

2. How would you rate your current sleeping habits? (Please circle one): Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:

_____
_____

3. How many times per week do you generally exercise? _____
What types of exercise do you participate in? _____

4. Please list any difficulties you experience with your appetite or eating problems: _____
_____

5. Are you currently experiencing overwhelming sadness, grief or depression? □ No □ Yes
If yes, for approximately how long?_____

6. Are you currently experiencing anxiety, panics attacks or have any phobias? □ No □ Yes
If yes, when did you begin experiencing this? _____

7. Are you currently experiencing any chronic pain? □ No □ Yes
If yes, please describe: _____

8. Do you drink alcohol more than once a week? □ No □ Yes

9. How often do you engage in recreational drug use? □ Daily □ Weekly □ Monthly □ Infrequently

10. Are you currently in a romantic relationship? □ No □ Yes

If yes, for how long? _____

On a scale of 1-10 (with 1 being poor and 10 being exceptional), how would you rate your relationship?
_____

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

Family Mental Health History

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 (e.g. father, grandmother, uncle, etc.)

Alcohol/Substance Use □ No □ Yes Anxiety □ No □ Yes
Depression □ No □ Yes
Domestic Violence □ No □ Yes Eating Disorders □ No □ Yes Obesity □ No □ Yes

Obsessive Compulsive Behavior □ No □ Yes Schizophrenia □ No □ Yes
Suicide Attempts □ No □ Yes
Posttraumatic Stress Disorder/Trauma □ No □ Yes

Describe:
_____
_____
_____

Additional Information

1. Are you currently employed? □ No □ Yes

If yes, what is your current employment situation? _____
_____

Do you enjoy your work? Is there anything stressful about your current work? _____
_____
_____

2. Do you have any children? □ No □ Yes

If yes, how many? What ages?: _____

3. What race/ethnicity do you identify with (optional)?
_____

4. Do you consider yourself to be spiritual or religious? □ No □ Yes

If yes, describe your faith or belief: _____
_____

5. What do you consider to be some of your strengths? _____
_____
_____

_____

6. What do you consider to be some of your weaknesses? _____
_____
_____
_____

7. What would you like to accomplish out of your time in therapy? _____
_____
_____