kTherapy / Brainspotting with Katherine
45 Lyme Road, Suite 310A • Hanover, NH 03755 • 833-4-BSPKAT (833-427-7528)

CLIENT INTAKE FORM

Today's Date:_____Referred by: _____

GENERAL INFORMATION

Name: _____ Date of Birth: _____ Age: _____
Street Address: _____
City, State, Zip: _____
Home Phone: _____ May I contact you at home?: ❍Yes ❍No Messages OK?: ❍Yes ❍No
Work Phone: _____ May I contact you at work?: ❍Yes ❍No Messages OK?: ❍Yes ❍No
Cell Phone: _____ May I contact your cell?: ❍Yes ❍No Messages OK?: ❍Yes ❍No

Marital Status: ❍Single ❍Cohabitating ❍Married ❍Separated ❍Divorced ❍Widowed

Children?: ❍Yes ❍ No If yes, custody status: _____
Household members: _____ Age: _____
_____ Age: _____
_____ Age: _____
_____ Age: _____

Name of Emergency Contact: _____ Relationship: _____
Emergency Contact's Phone #: _____

Name of Employer: _____ Title/Position: _____

Treatment of Minor Child

Parent or Legal Guardian Name _____ I give consent for treatment _____(initial)
Child Name_____ Age/Grade_____

SYMPTOM CHECKLIST (Rate intensity of symptoms currently present)

- **None** = This symptom not present at this time • **Mild** = Impacts quality of life, but no significant impairment of day-to-day functioning
- **Moderate** = Significant impact on quality of life / functioning • **Severe** = Profound impact on quality of life / functioning

	None	Mild	Moderate	Severe		None	Mild	Moderate	Severe
Depressed Mood	❍	❍	❍	❍	Hyperactivity	❍	❍	❍	❍
Appetite Disturbance	❍	❍	❍	❍	Delusions	❍	❍	❍	❍
Sleep Disturbance	❍	❍	❍	❍	Hallucinations	❍	❍	❍	❍
Fatigue/Low Energy	❍	❍	❍	❍	Aggressive Behaviors	❍	❍	❍	❍
Poor Concentration	❍	❍	❍	❍	Bingeing/Purging	❍	❍	❍	❍
Mood Swings	❍	❍	❍	❍	Anorexia	❍	❍	❍	❍
Agitation	❍	❍	❍	❍	Family Conflict	❍	❍	❍	❍
Elevated Mood	❍	❍	❍	❍	Weight Loss/Gain	❍	❍	❍	❍
Emotionality	❍	❍	❍	❍	Hopelessness	❍	❍	❍	❍
Irritability	❍	❍	❍	❍	Grief	❍	❍	❍	❍
Social Isolation	❍	❍	❍	❍	Sexual Problems	❍	❍	❍	❍
Worthlessness	❍	❍	❍	❍	Phobias	❍	❍	❍	❍
Panic Attacks	❍	❍	❍	❍	Obsessions/Compulsions	❍	❍	❍	❍
Self-Inflicted Wounding	❍	❍	❍	❍	Difficulty Making Friends	❍	❍	❍	❍
Financial Problems	❍	❍	❍	❍	Difficulty Keeping Friends	❍	❍	❍	❍

PURPOSE FOR VISIT

What brings you into therapy today? _____

_____

_____

_____

_____

_____

How did the issue arise? _____

_____

_____

_____

_____

Who is supportive of you? Where do you go for help? _____

_____

_____

PSYCHIATRIC HISTORY

Prior suicide attempts? ❍Yes ❍No

If yes, when?_____

Circumstances that led to the attempt: _____

_____

_____

Current suicidal thoughts? ❍Yes ❍No

If yes, please describe: _____

_____

_____

Have you had any prior therapy? ❍Yes ❍No

If yes, when and for how long? _____

What was the focus of previous treatment? _____

_____

Was it helpful? _____

Prior hospitalization for mental/emotional problems? ❍Yes ❍No

If yes, please describe (year/duration/reason for hospitalization): _____

_____

_____

_____

MEDICAL HISTORY

Are you currently taking ***any*** prescription medication? ❍Yes ❍No

If yes, please provide the following details (*to the best of your ability*):

Medication	Dose	Method	Physician

Are any of these medications for mental/emotional problems? ❍Yes ❍No

Do you have any medical conditions that may affect your treatment? ❍Yes ❍No

Please describe your overall health today: _____

_____

_____

Date of last visit to Physician: _____

Do you drink alcohol? ❍Yes ❍No If yes, how much do you consume in a week?: _____

Do you currently use drugs (street, non-prescription or herbal supplements)? ❍Yes ❍No

If yes, please describe your drug use: _____

_____

_____

ADDITIONAL INFORMATION

What do you consider to be your strengths?: _____

_____

_____

What do you like most about yourself?: _____

_____

_____

What do you consider to be your weaknesses?: _____

_____

_____

GENOGRAM

CLINICAL SUMMARY:_____

_____

_____

_____

_____

_____

_____

_____

_____

_____