Grace for Life Counseling and Consulting Associates
Belinda Richardson, Ph.D., LMFT
4940 Broadway, Suite 213
San Antonio, TX 78209
Phone: (210) 778-8256
brichardson@grace-for-life.com
Fax: (844) 602-4661

INTAKE FORM

Please fill out this form and bring it to your first session. If a minor is the primary client a parent or legal guardian must also attend the session. The information you provide here is protected as confidential information.

Name: _____
(Last) (First) (Middle Initial)

Name of parent/guardian (if under 18 years):
_____
(Last) (First) (Middle Initial)

Birth Date: _____ /_____ /_____ Age:____ Gender: □ Male □ Female

Marital Status:

- o Never Married
- o Domestic Partnership
- o Married
- o Separated
- o Divorced
- o Widowed

Education Status:

- o 8th Grade or Less
- o Grade 9-11
- o High School Diploma or Equivalent
- o Vocational/Technical
- o Some College
- o Associate Degree
- o Bachelor's Degree
- o Graduate School
- o Doctorate

Race:

- o African American/Black
- o American Indian/Alaska Native
- o Asian
- o Native Hawaiian or Other Pacific Islander
- o Caucasian/White

Ethnicity:

Are you Hispanic or Latino __ yes __no

Address:

_____
(Street and Number)

_____
(City) (State) (Zip)

Home Phone: _____

May we leave a message? __ Yes __ No

Cell/Other Phone: _____

May we leave a message? __ Yes __ No

May we send you text messages? __Yes __No

E-mail: _____

May we email you? __ Yes __ No

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

Please list any children/age:

_____

Referred by (if any):

_____
Are you currently or have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

- o No
- o Yes

If yes, please provide name of therapist/psychiatrist:

Have you ever been hospitalized for mental health treatment?

- o No
- o Yes

Have you ever received treatment for substance abuse?

- o No
- o Yes

Are you currently taking any prescription medication?

- o Yes
- o No

Please list: (If you need additional space list on back of last page)

_____

_____

Have you ever been prescribed psychiatric medication?

- o Yes
- o No

Please list and provide dates:

_____

_____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health? (please circle)

   Poor Unsatisfactory Satisfactory Good Very good

2. Please list any specific health problems you are currently experiencing:

_____

3. How would you rate your current sleeping habits? (please circle)

   Poor Unsatisfactory Satisfactory Good Very good

4. Please list any specific sleep problems you are currently experiencing:

_____

5. How many times per week do you generally exercise? _____

6. What types of exercise to you participate in?
_____

7. Please list any difficulties you experience with your appetite or eating patterns:
_____

8. Are you currently experiencing overwhelming sadness, grief, or depression?

o No
o Yes

If yes, for approximately how long?
_____

9. Have you had thoughts of suicide in the past year?

o Yes
o No

10. Are you currently experiencing anxiety, panic attacks, or have any phobias?

o No
o Yes

If yes, when did you begin experiencing this?

_____

11. Are you currently experiencing any chronic pain?

o No
o Yes

If yes, please describe:
_____

12. Do you drink alcohol more than once a week?

o No
o Yes

13. How often do you engage recreational drug use?

- o Daily
- o Weekly
- o Monthly
- o Infrequently
- o Never

14. Are you currently in a romantic relationship?

- o No
- o Yes

If yes, for how long? _____

15. On a scale of 1-10, how would you rate your relationship satisfaction? _____

16. 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 (father, grandmother, uncle, etc.).

Please circle any that apply and identify the family member

Alcohol/Substance Abuse	yes/no
Anxiety	yes/no
Depression	yes/no
Domestic Violence	yes/no
Eating Disorders	yes/no
Obesity	yes/no
Obsessive Compulsive Behavior	yes/no
Schizophrenia	yes/no

Suicide Attempts yes/no

ADDITIONAL INFORMATION:

1. Are you currently employed?

   - o No
   - o Yes

If yes, what is your current employer?

_____

If no, have long have you been unemployed or retired?

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

_____
_____
_____

2. Do you consider yourself to be spiritual or religious?

   - o No
   - o Yes

If yes, describe your faith or belief:

_____

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

_____
_____
_____
_____

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

_____
_____
_____
_____

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

_____
_____
_____

INSURANCE INFORMATION

Insured’s Name:_____

Address:_____

Insured’s SS#:_____

Date of Birth:_____

Insurance Provider:_____

Member ID_____

Employer/ EAP Provider:_____

Signature:_____

Date _____