EMPOWERING
MINDS TOGETHER

5308 Derry Ave. Suite L-201 Agoura Hills, CA 91301
(818)-422-1088
Empoweringmindstogether@gmail.com

Client Intake Questionnaire

Please fill in the information below and email to ***Empoweringmindstogether@gmail.com***
Please note: information provided on this form is protected as confidential information.

Personal Information

Name: Date:

Parent/Legal Guardian (if under 18):

Address: City: Zip:

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

Cell/Work/OtherPhone: May we leave a message? ☐Yes ☐No

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

DOB: Age: Gender:

Marital Status:

☐ Never Married ☐ Domestic Partnership ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Emergency Contact

Name: Phone Number:

Address:

Relation to Patient:

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History

Have you previously received any type of mental health services? ☐ No ☐ Yes

Previous Psychiatrist/Therapist/Practitioner:

Are you currently taking any prescription medication? ☐ No ☐ Yes

If yes, please list:

Have you ever been prescribed psychiatric medication? ☐ No ☐ Yes

If yes, please list and provide dates:

General and Mental Health Information

1. How would you rate your current physical health? (Please check 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?

☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very good

Please list any specific sleep problems you are currently experiencing:

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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 ☐ Never

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

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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?

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

I I. 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.)

	Please Check		List Family Member
Alcohol/Substance Abuse	☐ No	☐ Yes	
Anxiety	☐ No	☐ Yes	
Bipolar	☐ 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	

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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 consider yourself to be spiritual or religious? ☐ No ☐ 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?

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Insurance / Payment Information

Please Note: Empowering Minds Together, Inc. files insurance as a courtesy to you, and you, not your insurance company are ultimately responsible for your bill. Please expect to pay your portion of copay, coinsurance, deductible, or self-pay payments at the time of service and carefully review our ***Terms of Service*** document for more information regarding our cancellation policy/fees.

Self-Pay: ☐ No ☐ Yes

Primary Insurance: _____ Member ID: _____

Secondary Insurance: _____ Member ID: _____

Referral Source (if any): _____

If not, how did you hear about us: _____

Disclosure and Consent for Treatment

Confidentiality and Terms of Service

In general, we must have your written release to provide information to others. Please see our ***Privacy Policy*** and ***Terms of Service*** documents for exceptions and for more information.

Patient Acknowledgment

By my signature, I acknowledge Empowering Minds Together, Inc. has made ***Privacy Policy*** and ***Terms of Service*** documents available. I, the undersigned, have reviewed all documents and consent to treatment.

I, the undersigned, hereby authorize Empowering Minds Together, Inc. and/or it's staff to the extent required to assure payment to disclose any diagnosis and pertinent treatment information to a designated person, corporation, government agency or third party payer in order to receive payment for services rendered.

Patient Name (print): _____

Patient or legally authorized individual signature: _____

Relation to patient: _____ **Date:** _____

Please email completed form to Empoweringmindstogether@gmail.com