Meghan McGee, MSW, LICSW
Resilience Counseling

617-780-5627
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Client Intake Form

Today's Date: ___________________________

Name: ____

Birth Date: ______ /______ /______ Age: ________ Gender: _____________________

Race/Ethnicity: ____

Address: ____

Home Phone: ______________________ May I leave a message here? ☐Yes ☐ No

Cell/Phone: ___________________ May I leave a message here ☐Yes ☐ No

Referred by/how you found out about my services:
____

Insurance Company: ______________________ Subscriber Name: ________________________

Policy Holder's Name______________________ Policy Holder's D.O.B: __________

Social Security Number: __________________ Group Number:_______________

Mental Health Co-Payment: ___________

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?

☐ No ☐ Yes Please list:

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

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

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

☐ No ☐ Yes If yes, for approximately how long? ______________________________________

6. Are you currently experiencing anxiety, panic 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 use alcohol? ☐ No ☐ Yes If so how often? ________________________

9. Do you engage in recreational drug use? ☐ No ☐ Yes If so how often, and which drug(s)?

10. Are you currently in a romantic relationship?

☐ No ☐ Yes If yes, for how long? _________________
On a scale of 1-10, 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,maternal grandmother, uncle, etc.).

	Please Circle		List Family Member
Alcohol/Substance Abuse	☐ Yes	☐ No	
Anxiety	☐ Yes	☐ No	
Depression	☐ Yes	☐ No	
Domestic Violence	☐ Yes	☐ No	
Eating Disorders	☐ Yes	☐ No	
Obsessive Compulsive Behavior	☐ Yes	☐ No	
Major mental illness	☐ Yes	☐ No	
Suicide Attempts Or hospitalizations	☐ Yes	☐ No	
Other (please describe			

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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. Overall, how well do you feel you take care of yourself?

6. Who are your supports?

7. What would you like to accomplish out of your time in therapy? How can I help?

I look forward to working together~