RSM Intake Information

Please provide the following information for my records. Leave blank any question you would rather not answer. Print out and bring this form with you to your Intake Session.

Today's Date: _____

A. Identification

Client's Name: _____

If Client is a Minor: (name of parent/guardian) _____

Date of Birth: _____ Age: _____ Gender at Birth: ☐Female ☐ Male

Phone Number: _____ May I leave a message? ☐Yes ☐No

Email: _____

(Please be aware emails might not be confidential.)

Address: _____

City: _____ State: _____ Zip: _____

Circle One: Single Married Divorced Re-married

Have children? Yes: _____ No: _____ If yes, how many? _____

Are you currently taking prescribed psychiatric medication (antidepressants or others)?

☐Yes ☐No If yes, please list:_____

_____

B. Referral: (Who referred you?) Name: _____

C. Self-Identity

Family of Origin: How many siblings did you have growing up? _____

Where did your birth fit in? (i.e., First child? Youngest?) _____

What role did you fill? (i.e., caretaker, peace-maker, scape-goat, etc.) _____

_____

Religious and Racial/Ethnic Identification

Religious denomination/affiliation? _____

How important are spiritual concerns in your life?

_____

_____

Ethnicity/National Origin: _____ Race: _____

Or other similar way you identify yourself and consider important: _____

D. Chief Concerns/Issues

a. What is your main concern for seeking neuro-emotional therapy at this time?

_____

_____

_____

_____

_____

_____

b. Symptoms—frequency, duration, intensity, latency, recurrence, course, distress, etc.

_____

_____

c. What is the desired outcome for your main concern? _____

_____

_____

E. Prior Treatment

Have you ever tried to resolve this issue previously: (circle one) ☐Yes ☐No

If yes, change efforts have included: _____

_____

_____

_____

Outcome: How successful was treatment? (Satisfaction and/or difficulties) _____

_____

_____

F. Physical concern(s): Please list any persistent physical symptoms or health related concerns you are presently experiencing. _____

_____

_____

_____

How do you rate your… (circle one)

Sleep: Poor Good Excellent

Diet: Poor Good Excellent

Exercise: Poor Good Excellent

Overall Health: Poor Good Excellent

Have you ever experienced?

Extreme Depression ☐Yes ☐No

Extreme Anxiety ☐Yes ☐No

Panic Attacks ☐Yes ☐No

Phobias	☐Yes ☐No
Unexplained Loss of Time	☐Yes ☐No
Alcohol/Substance Abuse or Dependence	☐Yes ☐No
Eating Disorders	☐Yes ☐No
Night Terrors	☐Yes ☐No

G. Suicide risk factors:

If you have experienced any type of suicide ideation or suicide attempts, please check here at box A ( ). If you have not ever experienced any type of suicide ideation or suicide attempts, please check box B ( ).

If box "A" was checked, please check appropriate boxes below and enter the appropriate code for the time period as follows: **d** = last 30 days, **m** = during the last 6 months, **y** = last 12 months or year, **z** = in the last 10 years, or **L** = early in my life.

- ❑ Have passive death wish? _____ ❑ Made past suicide gestures? _____
- ❑ Experiencing persistent suicide ideation? _____
- ❑ Suicide plans that involve a highly lethal method? _____
- ❑ Intention and the means to carry it out? _____
- ❑ Talked with therapist about suicide intentions/thoughts in the past? _____

H. Current Psychological Factors: Client's self evaluation (circle a number)

- ❑ Agitation, irritability, rages, violence Low 1 2 3 4 5 High
- ❑ Social support system (nearby friends, family) Strong 1 2 3 4 5 Weak
- ❑ Self-regard Extremely Positive 1 2 3 4 5 Extremely Negative
- ❑ Impulsivity (low self-control, distractibility) Low 1 2 3 4 5 High
- ❑ Depression (blunted emotions, anhedonia, isolation) None 1 2 3 4 5 Extreme

I. Emergency information: If some kind of emergency arises and we cannot reach you directly, and/or we need to reach someone close to you, whom should we call?

1. Name: _____

Phone: _____

Relationship:

_____

Address: _____

A significant other/nearest friend or relative not residing with you:

2. Name: _____

Phone: _____

Relationship:

_____

Address: _____

J. Additional Information: Is there anything else you feel is relevant or important that you want me to know prior to your RSM session work?

_____

_____

_____

_____

_____

_____

_____