BEST LIFE COUNSELING AND WELLNESS
Ruthann Goozdich, MA, NCC, LPC
1345 E. Chandler Blvd. Suite 105
Phoenix, AZ 85048
724-255-8801

I N T A K E F O R M

Please note: Information you provide here is protected as confidential information.

Please fill out this form and bring it to your first session.

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:
□ Never Married □ Domestic Partnership □ Married □ Separated
□ Divorced □ Widowed

Spouse/Significant other's name: _____
Please list any children/ages:_____
_____

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 text you: □ Yes □ No
*Please note: Text correspondence is not considered to be a confidential medium of communication.

E-mail: _____ May we email you? □ Yes □ No
*Please note: Email correspondence is not considered to be a confidential medium of communication.

Referred by (if any): _____

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?
□ Yes
□ No
Please list:
_____
_____

Have you ever been prescribed psychiatric medication?
□ Yes
□ 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

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 to 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, when did you begin experiencing this? _____

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 drink alcohol more than once a week? □ No □ Yes
How many drinks per week?_____

9. How often do you engage in recreational drug use?
□ Daily □ Weekly □ Monthly □ Infrequently □ Never

10. Are you currently in a romantic relationship (incl. marriage)? □ 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 (father, grandmother, uncle, etc.).

Please Circle		List Affected Family Member
Alcohol/Substance Abuse	yes / no	
Anxiety	yes / no	
Depression	yes / no	
Domestic Violence	yes / no	
Eating Disorders	yes / no	
Obesity	yes / no	
OCD	yes / no	
Schizophrenia	yes / no	
Suicide Attempts	yes / no	

ADDITIONAL INFORMATION:

12. Are you currently employed? □ No □ Yes
If yes what is your occupation? _____
_____
Do you enjoy your work? □ No □ Yes Describe anything stressful about your current work?_____
_____

13. Do you consider yourself to be spiritual or religious? □ No □ Yes
If yes, describe your faith or belief:_____
_____

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

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

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

17. Please list any other information you feel is important to share:
_____
_____
_____

18. How did you hear about this office? _____

Client Signature:_____Date:_____

Signature of Parent/Guardian: _____Date: _____