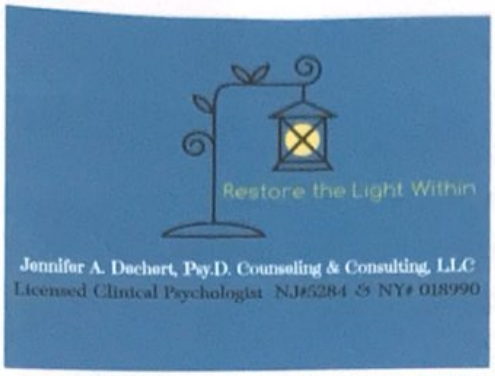

JENNIFER A. DECHERT, PSY.D COUNSELING & CONSULTING, LLC

LICENSED CLINICAL PSYCHOLOGIST (NJ#5284 & NY#018990)

INDIVIDUAL COUNSELING INTAKE FORM

Please provide the following information and answer the questions below. If you believe that a question does not pertain to you, you may leave it blank. Please note: information you provide here is protected as confidential information. Please fill out this form and bring it to your first session.

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

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

Birth Date: _____/_____/_____ Age: _____ Gender: □ Male □ Female □ Transgender Other:

Local Address: _____City/State: _____ Zip: _____

Home Address: _____City/State: _____ Zip: _____
*****Write SAME if home address is same as local

Primary Phone: ( ) May we leave a message? □ Yes □ No

Secondary Phone: ( ) May we leave a message? □ Yes □ No

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

I give permission to Dr. Dechert to email me my Statement of Insurance (Superbill) for out of network insurance to above email address: Circle: Y or N *Please let Dr. Dechert know if email address changes.

Referred by (if any): _____

Relationship Status:
□ Single □ Serious dating or committed relationship □ Domestic Partnership
□ Married □ Separated □ Divorced □ Widowed

Immediate Relationships (Spouse, Children, Siblings, Parents, etc; use additional space as necessary):

Name	Relationship	Age	Location

_____

_____

_____

What is your reason for seeking counseling at this time? _____

_____

Have you previously received any type of mental health services (counseling, psychiatric services, etc.)?

□ No

□ Yes: _____

Therapist/Practitioner Dates

_____

Therapist/Practitioner Dates

Have you ever been prescribed psychiatric medication?

□ No

□ Yes: _____

Medication Dates Prescribing Doctor

_____

Medication Dates Prescribing Doctor

_____

Medication Dates Prescribing Doctor

Have you previously been hospitalized for a psychiatric reason (including substance abuse treatment)?

□ No

□ Yes, when: _____

Please indicate if and when you have had the following experiences: (X)	Never	Within the past year	More than a year ago	Both
Purposely injured yourself without suicidal intent? *(e.g., cutting, hitting, burning, hair pulling, etc.)*				
Seriously considered attempting suicide?				
Made a suicide attempt?				
Seriously considered injuring another person?				
Intentionally caused serious injury to another person?				
Had unwanted sexual contact(s) or experience(s)?				
Experienced harassing, controlling, and/or abusive *behavior from another person? (e.g., friend, family* member, partner, authority figure, etc.)				
Legal issues?				

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. On a scale of 1-10 (with 10 being great) how would you rate your current physical health? _____

Please list any specific health problems you are currently experiencing, including any disabilities:

_____

2. On a scale of 1-10 (with 10 being great) how would you rate your current sleeping habits? _____

How many hours of sleep per night do you average? _____

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:

_____

Have you ever suffered from an eating disorder?

□ No
□ Yes, when? _____

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

□ No
□ Yes, for approximately how long? _____

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

□ No
□ Yes, for approximately how long? _____

7. Are you currently experiencing any chronic pain?

□ No
□ Yes, please describe _____

8. How often do you drink alcohol? □ Daily □ Weekly □ Monthly □ Infrequently □ Never
Describe your alcohol use: _____

9. How often do you use recreational drugs (or other drugs not prescribed to you)?

□ Daily □ Weekly □ Monthly □ Infrequently □ Never
What drugs have you used in the past 30 days? _____

10. Do you smoke cigarettes?

□ No
□ Yes, for approximately how long and how much? _____

11. Are you currently in a romantic relationship?

□ No
□ Yes, for approximately how long? _____

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

11. Describe any significant life changes or stressful events you have experienced recently:

_____

_____

12. Name of Primary Care Physician or Pediatrician _____

Date of last visit _____

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 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	

Other:

ADDITIONAL INFORMATION:

1. Are you currently employed? □ No □ Yes

If yes, describe 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. Have you ever been enlisted in any branch of the U.S. Military? □ No □ Yes

If yes, when and in what role: _____

If yes, did your military experiences include any traumatic or highly stressful experiences? □ No □ Yes

4. What is the most important thing that you would you like to accomplish in therapy?

_____

_____

_____

EMERGENCY CONTACT INFORMATION
The following information will only be used in case of emergency.
Emergency contact person(s): _____

Relationship to you: _____

Phone number(s): _____

Address: _____

Form Updated: 12-29-21