SARA MILMOE COUNSELING AND RECOVERY SERVICES

Initial Client Intake Form

Please provide the following information for our records. Leave blank any question you would rather not answer. Information you provide here is held to the same standards of confidentiality as your therapy.

Today's date: _____

Name: _____
(Last) (First) (MI)

Date of birth: ___ /___ /____ Age: ____ Gender: ☐ Female ☐ Male ☐ Trans Preferred pronoun: ☐ She/Her ☐ He/Him ☐ They/Them

Marital status: ☐ Never married ☐ Partner ☐ Civil Union ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Number of children: _____ Name(s) & age: _____

Living situation: ☐ Partner/spouse ☐ Parent(s) ☐ Family ☐ Children ☐ Roommate(s) ☐ Alone ☐ other_____

Local Address:

_____
(Street address and apt number as applicable)

_____
(City) (State) (Zip)

Home/Work phone: _____/_____ May I leave a voice mail msg? ☐ YES ☐ NO

Cell phone: _____ May I leave a voice mail msg? ☐ YES ☐ NO

Text messages: ☐ YES ☐ NO **I agree to confirm receipt of text messages the same day** ~ initials_____

* Texting is to be confined to scheduling only (either setting or changing appointments). If you don't receive a confirmation regarding your request your message may not have been received. Try again!

Please note appointment cancellations require 24 hour notice in order to avoid late cancel/no show fee ($150.00).

E-mail: _____May I email you? ☐ YES ☐ NO

***Please be aware that E-mail and Text messaging is not encrypted and therefore not considered secure/confidential**.

Person to contact in case of an emergency:

_____ _____ _____ Release on file: ☐ Yes ☐ No
(Name) (Relationship to client) (Phone)

How did you find me?

☐ www.saramilmoe.com ☐ Psychology today ☐ Google business website ☐ Personal/Professional referral

☐ Other: _____ Who were you referred by: _____

May I thank this person? ☐Yes ☐No

What brought you in to see me today? _____

_____

_____

_____

_____

_____

Please send completed forms to:
Sara Milmoe Counseling and Recovery Services
1650 38th St. Boulder Healing Hub, Suite 100E, Boulder, Co 80301-2624
Revised 07/2022

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HEALTH AND SOCIAL INFORMATION

1. How is your physical health at present? (Please circle) Poor Unsatisfactory Satisfactory Good Very good
2. Please list any chronic health problems or concerns:_____
   (Examples: asthma, hypertension, diabetes, headaches, stomach pain, seizures, etc.).
   Health related medications: _____
   Primary Care Physician: _____ Phone: _____
3. Are you having any problems with your sleep habits? ☐ YES ☐ NO hours /night_____
   If yes, please describe: _____
4. Are you having any difficulty with appetite or eating habits? ☐ YES ☐ NO
   If yes, check where applicable: ☐ eating less ☐ eating more ☐ binging ☐ purging
5. Have you experienced significant weight change in the last 3 months? ☐ YES ☐ NO If yes: Loss or Gain # _____
6. In the last year, have you experienced any significant life changes or stressors? _____

_____

_____

7. Have you had an increase in alcohol or drug use? ☐ YES ☐ NO **Please complete the following:**

Substance use	Amount & Frequency	Duration of problem use	Last use	Age of first use	Increased tolerance	Attempts to Hide
Alcohol					☐ YES ☐ NO	☐ YES ☐ NO
Cocaine					☐ YES ☐ NO	☐ YES ☐ NO
Marijuana					☐ YES ☐ NO	☐ YES ☐ NO
Opiates Pain Rx					☐ YES ☐ NO	☐ YES ☐ NO
Sedative/benzos					☐ YES ☐ NO	☐ YES ☐ NO
Stimulant/meth					☐ YES ☐ NO	☐ YES ☐ NO
Hallucinogens					☐ YES ☐ NO	☐ YES ☐ NO
Tobacco					☐ YES ☐ NO	☐ YES ☐ NO
Caffeine					☐ YES ☐ NO	☐ YES ☐ NO

IS USE GREATER THAN A 10-YEAR HISTORY? ☐ YES ☐ NO WHAT IS LONGEST PERIOD OF SOBRIETY? _____WHEN? _____
IS THERE ABUSE OF MULTIPLE SUBSTANCES? ☐ YES ☐ NO
IS THERE A CO-EXISTING MENTAL HEALTH DIAGONOSIS? ☐YES☐ NO If yes, please provide :_____
AA/SUPPORT GROUP INVOLVEMENT: CURRENT? YES ☐ NO ☐ PAST? YES ☐ NO ☐ HAVE A SPONSOR? YES ☐ NO ☐
PATIENT RESOURCES: HOUSING? YES ☐ NO ☐ SOBER SUPPORT? YES ☐ NO ☐ EMPLOYMENT? YES ☐ NO ☐
CURRENT AND PAST WITHDRAWAL SYMPTOMS/BEHAVIORS FROM ALCOHOL/DRUG USE (**CHECK ALL THAT APPLY**):
☐ Aggression/Assault ☐ Agitation ☐ Weakness ☐ Seizures ☐ Tremors ☐ Blood Pressure Changes
☐ Irritability ☐ Tachycardia ☐ Diarrhea ☐ Fever/Chills ☐ Blackouts ☐ Nausea/Vomiting ☐ Delirium

Have you had previous psychotherapy? ☐ YES ☐ NO Reason _____

_____

Are you currently taking prescribed psychiatric medications (antidepressants, mood stabilizers, etc.)? ☐ YES ☐ NO
If Yes, please list: _____

_____

If No, have you been previously prescribed psychiatric medication? ☐ YES ☐ NO
If Yes, please list: _____

_____

- Please provide Psychiatrist/Doctor's contact information and sign a release of information for collateral contact
- Name of Prescriber:_____Phone: _____

Are you hopeful about your future? ☐ YES ☐ NO
Are you having current suicidal thoughts? ☐ Frequently ☐ Sometimes ☐ Rarely ☐ Never
Have you had suicidal thoughts in the past? ☐ Frequently ☐ Sometimes ☐ Rarely ☐ Never When:_____
Are you having current homicidal thoughts? ☐ YES ☐ NO Have you previously? ☐ YES ☐ NO When? _____

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Are you currently experiencing? Circle all that apply and rate those on a scale of 1-10 (10 being the worst)

1.	Depressed	1 2 3 4 5 6 7 8 9 10	Experienced in the past? ☐
2.	Mood or Sadness	1 2 3 4 5 6 7 8 9 10	Experienced in the past? ☐
3.	Irritability/Anger	1 2 3 4 5 6 7 8 9 10	Experienced in the past? ☐
4.	Mood Swings	1 2 3 4 5 6 7 8 9 10	Experienced in the past? ☐
5.	Rapid Speech	1 2 3 4 5 6 7 8 9 10	Experienced in the past? ☐
6.	Racing Thoughts	1 2 3 4 5 6 7 8 9 10	Experienced in the past? ☐
7.	Anxiety	1 2 3 4 5 6 7 8 9 10	Experienced in the past? ☐
8.	Constant Worry	1 2 3 4 5 6 7 8 9 10	Experienced in the past? ☐
9.	Panic Attacks	1 2 3 4 5 6 7 8 9 10	Experienced in the past? ☐
10.	Phobias	1 2 3 4 5 6 7 8 9 10	Experienced in the past? ☐
11.	Sleep Disturbances	1 2 3 4 5 6 7 8 9 10	Experienced in the past? ☐
12.	Hallucinations	1 2 3 4 5 6 7 8 9 10	Experienced in the past? ☐
13.	Paranoia	1 2 3 4 5 6 7 8 9 10	Experienced in the past? ☐
14.	Poor Concentration	1 2 3 4 5 6 7 8 9 10	Experienced in the past? ☐
15.	Alcohol/Substance Abuse	1 2 3 4 5 6 7 8 9 10	Experienced in the past? ☐
16.	Frequent Body Complaints (e.g., headaches)	1 2 3 4 5 6 7 8 9 10	Experienced in the past? ☐
17.	Eating Disorder	1 2 3 4 5 6 7 8 9 10	Experienced in the past? ☐
18.	Body Image Problems	1 2 3 4 5 6 7 8 9 10	Experienced in the past? ☐
19.	Repetitive Thoughts (e.g., Obsessions)	1 2 3 4 5 6 7 8 9 10	Experienced in the past? ☐
20.	Repetitive Behaviors (e.g., Counting)	1 2 3 4 5 6 7 8 9 10	Experienced in the past? ☐
21.	Poor Impulse Control (e.g., ↑ spending)	1 2 3 4 5 6 7 8 9 10	Experienced in the past? ☐
22.	Self-Mutilation	1 2 3 4 5 6 7 8 9 10	Experienced in the past? ☐
23.	Sexual Abuse	1 2 3 4 5 6 7 8 9 10	Experienced in the past? ☐
24.	Physical Abuse	1 2 3 4 5 6 7 8 9 10	Experienced in the past? ☐
25.	Emotional Abuse	1 2 3 4 5 6 7 8 9 10	Experienced in the past? ☐

OCCUPATIONAL INFORMATION:

Are you currently employed? ☐ YES ☐ NO

If yes, who is your current employer/position? _____

If yes, are you happy at your current position? _____

Please list any work-related stressors, if any: _____

_____

Do you have current legal issues? ☐ YES ☐ NO_____

Financial concerns? ☐ YES ☐ NO_____

RELIGIOUS/SPIRITUAL INFORMATION

Do you consider yourself to be religious and/or spiritual? ☐ YES ☐ NO

If yes, please describe: _____

_____

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FAMILY HISTORY:

Are your parents: ☐ still together ☐ divorced, when: _____ ☐ remarried ☐ unmarried ☐ Deceased

If yes; whom: _____ when: _____ their age at death: _____

Number of siblings:___ Names & ages: _____

Do you have good sources of support? ☐ YES ☐ NO whom? _____

_____

FAMILY MENTAL HEALTH HISTORY:

Has anyone in your family (either immediate family members or relatives) experienced any mental health related illnesses or addiction issues? If so, briefly note:_____

_____

_____

_____

_____

OTHER INFORMATION:

What do you like most about yourself?_____

_____

_____

What do you consider to be your strengths?_____

_____

_____

What coping strategies do you use when you are stressed? _____

_____

_____

_____

What are your overall goals for therapy? _____

_____

_____

_____

What do you feel you need work on first? _____

_____

_____

_____

Are there other things you would like me to know about you or questions you have about the therapeutic process?

_____

_____

_____

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