Loving The Self Therapeutic Services LLC
Psychological & Forensic Services
Client Intake Form

The following intake form is to be completed by all new clients. You are welcome to print the paper version of this form and bring it with you to your appointment. The answers you provide will become part of your confidential mental health records. If you have any questions, feel free to discuss it with Dr. Kane.

Date: _____ /____ /_____

First Name: _____ Last Name: _____
SS#: _____ Birth Date: _____
Address: _____ Place of Birth _____
City: _____ State _____ Zip: _____
Primary Phone: _____ Ext: _____ Work Phone: _____ Ext: _____

Cell Phone: _____ Email: _____

Employer: _____
Occupation/Position:: _____ How Long: _____

Education Degree: _____ Field of Study: _____

History/Background

Have you had any previous mental health treatment? _____ Yes _____ No
If yes, please provide details: when, where, how long, provider name, medications, etc.

Are you currently (or in recent past) taking any prescription or over the counter medications? If yes, please provide details: _____ Yes _____ No

Does anyone else in your family (blood relatives) suffer from any mental illness? If yes, please provide details: _____ Yes _____ No

Do you drink alcohol? How much, how often, any blackouts, etc? If yes, please provide details: Yes No

Do you use any other recreational drugs? If yes, please provide details (what drugs, how often, last use, etc.): _____ Yes _____ No

Have you ever suffered from any type of eating disorder? If yes, please provide details (what drugs, how often, last use, etc.): _____ Yes _____ No

Have you ever been charged with a crime, arrested or convicted? If yes, please provide details: Yes No

Do you have any work-related problems or difficulties in school? If yes, please provide details: _____ Yes _____ No

Do you have a history of trauma (any kind of abuse, neglect, victim of natural or other disaster, etc.)? If yes, please provide details: _____ Yes _____ No

Symptom Checklist

Sleep:	___ No Problems	___ Not Enough	___ Trouble Getting Up	___ Nightmares	___ Too Much Sleep
Appetite	___ No problem	___ No interest	___ Increased Appetite	___ Carbohydrate Craving	
Energy	___ Normal	___ Increased	___ Low	___ Up and Down	
Interest in Sex	___ Normal	___ Increased	___ Low		
Concentration	___ Normal	___ Somewhat Difficult	___ Poor	___ Terrible	
Memory:	___ Good	___ Some Difficulty	___ Poor		
Depressed or Sad:	___ All the Time	___ Most Days	___ Some Days	___ Not at All	
Suicidal Thoughts:	___ All the Time	___ Most Days	___ Some Days	___ Not at All	
Past suicidal attempts	___ No	___ Yes			
If yes, please provide details:					
Anxiety:	___ Panic Attacks	___ All the Time	___ Most Days	___ Some Days	___ Not at All
Anger/Irritation:	___ All the Time	___ Most Days	___ Some Days	___ Not at All	

Any other comments: _____