Lana Royle, Royle LLC

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Client Intake Information

Date: _____

Client name:_____ Date of Birth:_____

Age:_____ Sex:_____ Client Social Security#:_____

Current Address:_____ City_____ State:_____ Zip:_____

Home Phone #:_____ May I leave a message? Yes or No (circle one)

Cell #:_____ May I leave a message? Yes or No (circle one)

email_____

_____ (initial) By providing my email address, I consent to having emails containing confidential information, wither clinical and/or financial in nature, sent to me. I understand that my email address will not be used for any other purpose

If client is a minor (under the age of 18 years old) please fill out the next section.

Parent/ Guardian:_____
_____

Parent/ Guardian's Address (if different than above):_____

City:_____ State:_____ Zip:_____

Parent/Guardian's Home#:_____ May I leave a message? Yes or No (circle one)

Cell #_____ May I leave a message? Yes or No (circle one)

Parent/Guardian's SS#_____ Parent/Guardian's

email_____

_____ (initial) By providing my email address, I consent to having emails containing confidential information, wither clinical and/or financial in nature, sent to me. I understand that my email address will not be used for any other purpose

In case of an emergency please contact:

Name: _____

Relationship to you:_____

Phone:_____

Referral source:_____

INSURANCE INFORMATION

Name of Insurance Company	Name of Insured and Date of Birth
Insurance Contact #	Group Number
Plan Name	Subscriber ID #
PreAuthorization # (if available)	Visit Copay Amount $

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

Please answer to the best of your ability. Not all questions will apply to you, and if that is the case, feel free to leave blank.

1. Have you ever been to outpatient therapy before? Yes or No (circle one)

   If yes, why did you go to therapy?

   _____
_____

2. Have you ever been admitted to inpatient therapy? Yes or No (circle one)

   If yes, why did you go o inpatient?

   _____
_____

3. What is your current living situation (example: by self, with others)?

   _____
_____

4. How would you rate your current physical health?

   Poor Unsatisfactory Satisfactory Good Very Good

5. How would you rate your current sleeping habits?

   Poor Unsatisfactory Satisfactory Good Very Good

   Please list any specific sleep problems you are experiencing

   _____
_____
_____

6. How many times a week do you generally exercise?_____

   What types of exercise to you participate in?_____

7. Please list any difficulties you have with appetite or eating.

   _____
_____
_____

8. Are you currently experiencing any sadness, grief or depression? Yes or No (circle one)

   If yes, for approximately how long? _____

9. Are you currently experiencing anxiety, panic attacks or have any phobias? Yes or No (circle one)

   If yes, please describe.

   _____

10. Do you drink alcohol? Yes or No (circle one)

    If yes, how many drinks per week on average do you consume?

    _____

11. Do you use any recreational drugs? Yes or No (circle one)

    If yes, what substance(s) and how often?

    _____
    _____
    _____

12. Are you currently in a romantic relationship? Yes or No (circle one)

    If yes, for how long?_____

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

13. What significant life events or stressors have you experiences recently?

    _____
    _____
    _____
    _____
    _____

FAMILY MENTAL HEALTH HISTORY

In the section below please indicate if there is a family history of any of the following. If yes, please indicate the family member's relationship to you (father, grandmother, uncle, etc.) in the space provided.

Alcohol/Substance Abuse or Addiction	Yes or No	Family member(s):
Anxiety	Yes or No	Family member(s):
Depression	Yes or No	Family member(s):
Domestic Violence	Yes or No	Family member(s):
Eating Disorders	Yes or No	Family member(s):

Obesity	Yes or No	Family member(s):
Obsessive Compulsive Disorders	Yes or No	Family member(s):
Schizophrenia	Yes or No	Family member(s):
Suicide (or suicide attempts)	Yes or No	Family member(s):

ADDITIONAL INFORMATION

1. Are you currently employed? Yes or No

   If yes, what is your current employment situation?

   _____

   Do you enjoy your work? Is there anything stressful about your work?

   _____

2. Do you consider yourself spiritual or religious? Yes or No

   If yes, describe your faith or belief.

   _____

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

   _____

   _____

   _____

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

   _____

   _____

   _____

5. What would you like to accomplish through therapy?

   _____