Aimée Lim-Miller, MSW,LICSW
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INTAKE FORM

Please fill out this form and bring it to your first consultation session. You may use the back of this page if necessary.

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

NAME: ____
(Last) (First) (Middle Initial)

Name of parent/guardian (if under 18 years):

____
(Last) (First) (Middle Initial)

ADDRESS: ____
(Number and Street Name)

____
(City) (State) (Zip)

PHONE [H]:______________________ May I leave a message? ☐ Yes ☐ No
PHONE [C]:______________________ May I leave a message? ☐ Yes ☐ No
E-MAIL: ______________________ May I email you? ☐ Yes ☐ No
**Please note: Email correspondence is not considered to be a confidential medium of communication.*

BIRTH DATE: ___/___/___ **AGE:** _______ **GENDER** : ☐ Male ☐ Female ☐ _________
RACIAL IDENTITY: _______________ **ETHNIC IDENTITY:** _______________

MARITAL STATUS:
☐ Never Married ☐ Domestic Partnership ☐ Married
☐ Separated ☐ Divorced ☐ Widowed ☐ Other
Please list any children/age:

____

____

Referred by (if any): ____
Emergency Contact: (name)______________________(phone#)______________________

☐ May I contact this person in case of a medical emergency? ☐ Yes ☐ No

INSURANCE INFORMATION

Insurance name: BCBC HMO BCBS PPO other:______________
Subscriber Name: ______________________Date of birth:____________
Policy #: ______________________ Group # ______________
Primary Care Physician: ______________________ Phone: ______________

☐ Check here to authorize use of your insurance plan and submission of claims to the plan stated above.

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HISTORY

Have you previously received any type of mental health services (psychotherapy, psychiatric services, hospitalization, day treatment 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? _____________ How long?______________
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, for approximately how long?____________________________________

Any thoughts of self-harm, suicide or harm to others? ☐ No ☐ Yes
If yes, for approximately how long?______________________________________

Are you currently experiencing mood swings, racing or disorganized thought patterns? ☐ No ☐ Yes
If yes, for approximately how long?_______________________________________

6. Are you currently experiencing anxiety, panic attacks, or have any phobias?
☐ No ☐ Yes

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If yes, when did you begin experiencing this? ______________________________
How does your anxiety manifest?_______________________________________

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 If yes, how many drinks do you consume a week? ____

9.How often do you engage recreational drug use?
☐ Daily ☐ Weekly ☐ Monthly ☐ Infrequently ☐ Never
Please discribe use: ____

10. Are you currently in a romantic relationship? ☐ 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:
____
____
____

12. Have you witnessed any violence, trauma or loss? Please describe:
____
____
____

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(s)*
Alcohol/Substance Abuse	☐ No ☐ Yes	
Anxiety/ Panic Disorder	☐ No ☐ Yes	
Depression/ Bipolar	☐ No ☐ Yes	
Domestic Violence	☐ No ☐ Yes	
Eating Disorders	☐ No ☐ Yes	
Obesity	☐ No ☐ Yes	
OCD	☐ No ☐ Yes	
Schizophrenia	☐ No ☐ Yes	
Suicide Attempts	☐ No ☐ Yes	
Trauma/ PTSD	☐ No ☐ Yes	
Adoption	☐ No ☐ Yes	

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ADHD/ ADD	☐ No ☐ Yes	
Developmental Disability	☐ No ☐ Yes	
Autism Spectrum Disorder	☐ No ☐ Yes	
Behavioral Issues	☐ No ☐ Yes	
Gender Identity	☐ No ☐ Yes	
Personality Disorder	☐ No ☐ Yes	

ADDITIONAL INFORMATION:

1. Are you currently employed? ☐ No ☐ Yes If yes, what is your current employment situation?

____

Do you enjoy your work? ☐ No ☐ Yes
Is there anything stressful about your current work?

____

Have you served in the military? ☐ No ☐ Yes Division__________ Rank ________ Years served________
Military experience?____

2. Do you consider yourself to be spiritual or religious? ☐ No ☐ Yes 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 out of your time in therapy?

____
____
____

6. Is there any additional information you would like to share that would better understand you or your needs for therapy at this time?

____