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Whole Heart Healing

Therapy Intake Form

Thank you for taking the time to fill this form out in advance. It will help me get a better sense of you as an individual. This information will also help start the process which will optimize your time during your first appointment.

Note: This information is confidential

Name: _____ Date of Birth: _____

Age: _____ Gender: _____

Home/Mobile Phone: _____ Is it ok to leave a message at this number? Y/N _____

Work Phone: _____ Is it ok to leave a message at this number? Y/N _____

Email: _____ Is it ok to email you? Y / N _____

Mailing Address: _____

Highest Level of Education: _____ Are you currently enrolled as a student? Y / N _____

Current Employer: _____ Position Title: _____

Current Occupational Status: (i.e., F/T, P/T, self-employed, student, returning to work):

Primary Insurance: ID #: _____

Subscriber Name: _____ Subscriber DOB: _____

800 # on back of card for behavioral healthcare

Subscriber SSN:

How were you referred?

Relationship Status:

of Children/Ages:

Race/Ethnicity:

Religious/Spiritual Faith:

What brings you to therapy?

On a scale of 1(none) to 10 (severe), please rate the level of stress you are currently experiencing daily? 1 2 3 4 5 6 7 8 9 10

What do you hope to get out of therapy? If therapy succeeds, what will be different?

Have you been in therapy before? If so, when? Was it helpful? What was helpful?

Please answer the following questions using: 5 Excellent, 4 Good, 3 Average, 2 Poor, 1 Failing, N/A

How would you currently rate your physical health: _____

How would you currently rate your mental health: _____

How would you currently rate your spiritual health: _____

How would you currently rate the health of your relationships: _____

With respect to the above responses, please explain areas of concern:

Please list and describe any health/medical issues you have experienced, currently or in the past:

Name of Primary Care Physician: _____ Physician Phone # _____

Address: _____

Please list any prescription medications you are currently taking:

Please list any over the counter medications, vitamins, or herbal supplements you are currently taking:

Do you exercise: _____ If yes, how many times per week: _____

Please list substances used (over the past 6 months) and the frequency:

Have you ever had problems with work, relationships, health, the law, etc. due to your substance use? If yes, please describe:

Does anyone you live with have a problem with substances? If yes, please explain who and what the issue is:

When you were growing up, were there any problems with substance abuse in your family? Please describe: _____

Are you currently receiving any kind of mental health services? ____ If yes, please list name of practitioner and type of services you are receiving:

Have you ever been diagnosed with a mental illness? ____ If yes, please list illness(es) and date(s) first diagnosed:

Has anyone in your family ever been diagnosed with a mental illness? ____ If yes, please list relationship(s) and diagnosis:

Have you ever attempted suicide: _____ If yes please list date(s), your age at time of attempt(s) and what happened: _____

Have you ever been depressed for a significant length of time? _____ If so, please describe: _____

Have you ever experienced overwhelming levels of anxiety or panic? ____ If so, please describe: _____

Do you have any obsessive thoughts/behaviors that influence the quality of your life? ____ If so, please describe what and how:

Do you currently trouble sleeping: _____ If yes, please describe: _____

Are you currently having, or have you ever had any problems related to money, spending, gambling, credit cards or finances? _____ If so, please describe: _____

Do you currently or have you ever had problems with eating or with food: _____ If yes, please describe: _____

Do you have any concerns related to your weight and/or physical appearance? _____ If yes, please describe: _____

Have any aspects of your sexuality ever been a cause of concern for you? _____ If so, please describe: _____

Please describe what, if any experience you have had with any physical or sexual violence/abuse (as a victim, witness, or perpetrator)?

Please feel free to share any additional comments or concerns: _____

Thank You 😊