

Body Perspectives - intake Form for New Clients
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INDIVIDUAL QUESTIONNAIRE – Please use the back of pages or additional pages if needed

Name _____ Date of Birth _____ Age _____ Female _____ Male _____

Address _____ City, State, Zip _____

HomePhone _____ WorkPhone _____ Email _____

Are you currently employed? Yes _____ No _____ Full-time _____ Part-time _____

Where? _____ Position _____ How long at present job? _____

Please give a name and phone number of a person we could reach in case of an emergency

Are you currently under the care of a therapist? Yes _____ No _____

Name _____ Address _____

City, State, Zip _____ Phone _____ Fax _____

Are you currently under the care of a psychiatrist? Yes _____ No _____

Name _____ Address _____

City, State, Zip _____ Phone _____ Fax _____

Are you currently using any prescribed medication? Yes _____ No _____ If yes: name, purpose amount and prescribing doctor:

Have you ever been treated inpatient for an addictive disorder? Yes _____ No _____

Disorder (drugs/alcohol, sex, gambling, eating disorder, etc.): _____

Where _____ Length of stay _____ Length of sobriety/abstinence _____

Are you currently attending any 12-step programs? Yes _____ No _____

Program _____ Frequency? _____

Program _____ Frequency? _____

Have you ever received individual, couples, family outpatient counseling? Yes _____ No _____

1) Counselor: _____ When: _____
Length of Treatment: _____ For: _____

2) Counselor: _____ When: _____
Length of Treatment: _____ For: _____

*If more than two counselors, please list on back of this page.

Have you ever been hospitalized for a psychiatric diagnosis? Yes ___ No ___

Diagnosis: _____ Psychiatric Facility: _____

Where: _____ When: _____ Length of stay _____

*If more than one hospitalization, please list others.

Currently enrolled in school? Yes ___ No ___

Highest Academic Level Completed: _____ Major _____

Vocational Training: Yes ___ No ___ If yes, what skill? _____

Have you served in the military? Yes ___ No ___ When _____ Where _____

Have you had any legal problems in any areas in the past two years?

Describe: _____

In the past two years, have you been convicted of any offense? Yes _____ No _____

If yes, explain: _____

Are you currently involved in any of these legal situations?

Divorce proceedings _____ Child care/custody actions _____ Civil proceedings _____

Probation _____ Parole _____ Other _____

Please list your concerns and reasons for attending therapy at this time:

List the problems, situations, negative patterns you need to address:

What would be the best results or outcomes of the therapy for you? What would be the minimal results or outcomes for you?

Which tools and means of self-care do you use currently?

What distracts and interferes with your self-care?

Describe your behavior and mood if you become isolated or disconnected from those closest to you.

From which source do you derive hope? Describe your current source of hope.

What has worked for you to achieve your goals?

What has not worked for you to achieve your goals?

FAMILY OF ORIGIN

Describe the personality, characteristics and relationship for each of the following family members:

Mother: _____

Father: _____

ParentalFigure/StepMother: _____

ParentalFigure/StepFather: _____

Sibling(s): _____

What are your perceptions and awareness's concerning your family of origin?

Describe any particular event or person that had a significant effect on your life:

Compulsive/addictive behaviors in the family? (alcohol/drugs, sex, eating disorder, gambling, etc.) Father _____ Mother _____ Father's Parents _____ Mother's Parents _____

Siblings _____ Other _____ History: _____

Present Status: _____

Impression on the impact it had on you both growing up and in your adulthood: _____

Current Relationship Status: Single ____ Married ____ Committed ____ Divorced ____ Separated ____ Widowed ____ How Long? _____

Number of Marriages/Committed Relationships: _____

Reason for relationship ending (include ending date(s)):

Quality of relationship with your present partner: _____

Children (names and ages): _____

Relationship with Children: _____

DATING AND SEXUAL HISTORY

Early dating patterns: _____

Sexual Orientation: Heterosexual ____ Homosexual ____ Bi-sexual ____ A-Sexual ____

ALCOHOL/DRUG USEAGE:

Age at first use? _____ Age at first over usage of drugs or alcohol? _____
 Last use? _____
 Current Pattern of use: daily _____ weekends _____ binge _____ days per week _____ None
 What do you prefer to use? _____ Amount consumed in 24 hours: _____
 Number of years using? _____ Number of years heavy using? _____
 Longest period of abstinence? _____
 Do you see your drinking or drug use having a negative effect on your: family life _____
 social life _____ physical condition _____ emotional condition _____ finances _____ job _____
 reputation in the community _____
 I believe I am an alcoholic and/or addict: Yes _____ No _____ Don't know _____
 Do you now smoke or use smokeless tobacco products? Yes _____ No _____
 Product: _____ Years used? _____ Current use/amount: _____

History of the following:

Suicide Thoughts Yes _____ No _____ When: _____
 Suicide Plans Yes _____ No _____ When: _____
 Suicide Attempts Yes _____ No _____ When: _____
 Self Injury Behavior (cutting, scratching, etc) Yes _____ No _____ When: _____
 Please explain any yes answers:

How much concern do you have about yourself regarding the following:

	Extreme	Frequent	Periodic	Minimal	Not at all
Overeating	_____	_____	_____	_____	_____
Under eating or dieting	_____	_____	_____	_____	_____
Purging/vomiting	_____	_____	_____	_____	_____
Binge eating	_____	_____	_____	_____	_____
Exercising or running	_____	_____	_____	_____	_____
Weight or body	_____	_____	_____	_____	_____
Relationship dependency	_____	_____	_____	_____	_____
Sexual thoughts/behavior	_____	_____	_____	_____	_____
Care taking behaviors	_____	_____	_____	_____	_____
Perfectionism	_____	_____	_____	_____	_____
Gambling	_____	_____	_____	_____	_____
Money/Finances	_____	_____	_____	_____	_____
Isolating behaviors	_____	_____	_____	_____	_____
Working/busyness	_____	_____	_____	_____	_____

Describe what success would look like at the end of your therapy experience; _____

Anything else you believe would be important for me to know prior to our initial session: _____

**Thank you for taking the time to complete this assessment.
Steve Sommers**
