Client Intake Form

Note: This information is confidential

Demographic Information:

Client Name: ___________________________________ Gender: _______ Pronouns:_________ DOB: _______ Age: ___
Relationship Status: ____
Children: Yes / No How Many: _______________ Phone (where best reached at): _________________________________
Email: ____
Address: ____
Street City State Zip Code
Guardian Name: ____
Guardian Address: ____
Current Employment Status ____
Emergency Contact Name: ____
Emergency Contact Phone:____
Emergency Contact Relationship: ____
How did you hear about us / referred by? ____

___ Initial here if you would like to receive information pertaining to your psychological and intellectual well being via email or other media sources.*

Family Information:
Name of Parent: ____ Age: ___________________________________
Name of Parent: ____ Age: ___________________________________
Name of Siblings: ____ Age: ___________________________________
Name(s) of Child(ren):____ Age: ___________________________________
Name(s) of Child(ren):____ Age: ___________________________________
Name(s) of Child(ren):____ Age: ___________________________________

Behavioral Information – Circle any that apply to you:
Binge Eating Suicidal Attempts Take Drugs Cannot Keep a Job Insomnia Temper
Lack of Motivation Smoking Vomiting Alcohol Problem Workaholic Procrastination Crying
Phobia Temper Nervous Tics Aggressive Behavior Impulsivity Sleep Disturbance Compulsions
Difficulties Concentrating
Anything else: ____

Physical Information – Circle any that apply to you:
Headaches Stomach Trouble Skin Problems Dizziness Nervous Tics Dry Mouth Itchy Skin Palpitations
Fatigue Muscle Spasms Twitching Chest Pain Tensions Back Pain Rapid Heart Rate Hearing
Problems Unable to Relax Fainting Blackouts Numbness Tingling Watery Eyes Visual Disturbances
Bowel Disturbances Sweating Tremors Flushes
Anything else: ____

Do you have any current concerns about your physical health? Please specify:
____

Please list all current medications you are taking (prescription and over the counter medication:
____

Please list all medications you took within the past 12 months (leave out current medications):
____

Please list all other substances you consume currently or have in the past:
____

Please list any allergies or possible allergies you have:
____

Do you exercise regularly? Yes / No How often per week? ____
What kind of exercise do you perform? ____
What are your favorite leisure/recreation activities?____

Feelings – Circle any that apply to you:

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Angry Guilty Unhappy Annoyed Happy Bored Sad Conflicted Depressed Regretful Lonely
Anxious Tense Hopeless Envious Hopeful Excited Panicky Helpless Fearful Relaxed
Jealous Optimistic Energetic Restless

Personal Strengths

Personal Strengths: ____

What are your goals for seeing Blaire? ____

History of substance abuse? Yes/No, explain ____

____

History of prior counseling or treatment:

Reason: ____ Date: ______________

Reason: ____ Date: ______________

Reason: ____ Date: ______________

Reason: ____ Date: ______________

Legal history:

Arrest: __________________________________ Date: ____________ Consequence: _________________________

Arrest: __________________________________ Date: ____________ Consequence: _________________________

Medical History:

Issue: __________________________________ Date: ____________ Consequence: _________________________

Issue: __________________________________ Date: ____________ Consequence: _________________________

Issue: __________________________________ Date: ____________ Consequence: _________________________

Issue: __________________________________ Date: ____________ Consequence: _________________________

Social history:

Family mental health: ____

Peer pressures: ____

Living arrangements: ____

Monetary arrangements/ability: ____

Cultural Identification/Influences:

____

____

Goals:

Please describe your reason(s) for seeking counseling and what you wish to accomplish:

____

____

Spiritual Views:

Spiritual view: ____

Do you wish to incorporate your views into your sessions? ____

_________________________________ ____________________

Signature (Client/Guardian) Date

____

Printed Name (Client/Guardian)

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MINDFUL MEDICINALS STATEMENT OF UNDERSTANDING

Only a physician (MD) can diagnose, treat, and prescribe medicines for illness or disease. I am not an MD, I neither diagnose nor treat disease. Neither do I prescribe remedies. I make no claims for the medicinal actions of any herbal supplements. Any information offered on herbal supplements is based off of research, scientific evidence, and/or traditional use.

The role of an herbalist is to educate the client as a whole person. Herbal consults aim at examining and educating on the topics of lifestyle, diet, and supplementation of herbs and/or vitamins.

As an herbalist and not an MD, I advise you, the client, to seek professional medical advice regarding any illness or disease you are suffering from. I request that you share as much background health information as possible, and any concerns about your health and herbal supplementation with herbs or diet should be discussed with your doctor.

Blaire Edwards, Community Herbalist Intern
Mindful Medicinals

Please sign below once you have read and understood the above statement:

Name (print)______________________________ Date: ___________________

Signature______________________________________