OLIVE BRANCH PSYCHOTHERAPY

Dr. Stephen R. Parrish DMFT, LCPC
1601 2nd Ave. North - suite 514 (Columbus Center) Great Falls, Montana 59401: 406-217-2338

CLIENT INTAKE ASSESSMENT

Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information. Please fill out this form and bring it to your first session.

Name: _____
Last First M I

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

_____
Last First M I

Birth Date: _____ /_____ /_____ Age: _____ Gender: □ Male □ Female

Marital Status:
□ Never Married □ Domestic Partnership □ Married □ Separated □ Divorced □ Widowed

Please list any children/age: _____

Address: _____
Street & Number City State Zip Code

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Home Phone: _____ May we leave a message? □Yes □No

Cell/Other Phone: _____ May we leave a message? □Yes □No

E-mail: _____ May we email you? □Yes □No

*Please note: Email correspondence is not considered to be a confidential medium of communication.

Referred by (if any): _____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

□ No □ Yes, previous therapist/practitioner: _____ Dates: _____

Are you currently taking any prescription medication? □ Yes □ No

Medication Name	Dosage	Prescriber	Date Prescribed

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Additional Meds: _____

_____

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 one)
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? _____

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? □ Yes □ No

If yes, for approximately how long? _____

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

If yes, when did you begin experiencing this? _____

7. Are you currently experiencing any chronic pain? □ Yes □ No

If yes, please describe? _____

8. Do you drink alcohol more than once a week? □ No □ Yes

9. How often do you engage recreational drug use? □ Daily □ Weekly □ Monthly □ Infrequently □ Never

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? I------2------3------4-----5-----6----7----8-----9------I

Perfect OK Horrible

11. What significant life changes or stressful events have you experienced recently:_____

_____

_____

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
Alcohol/Substance Abuse	yes / no	
Anxiety	yes / no	
Depression	yes / no	
Domestic Violence	yes / no	
Eating Disorders	yes / no	
Obesity	yes / no	
Obsessive Compulsive Behavior	yes / no	
Schizophrenia	yes / no	
Suicide Attempts	yes / no	

ADDITIONAL INFORMATION:

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

_____

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

_____

2. Do you consider yourself to be spiritual or religious? □ Yes □ 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 weakness? _____

_____

_____

5. What would you like to accomplish out of your time in therapy? _____

_____

_____