



restoration productions

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INTAKE FORM

Please provide the following information for our records. Leave blank any question you would rather not answer. Information you provide here is held to the same standards of confidentiality as our therapy.

Please print out this form and bring it to your first session or allow yourself 30 minutes prior to your appointment to complete the form in the office.

-CLIENT INFORMATION-

Name: _____
(Last) (First) (Middle Initial)

Street Address:

(Street and Number)

(City) (State) (Zip)

Home Phone: () - Cell/Work Phone: () -

I give my permission to be called at: HOME Yes/No CELL/WORK Yes/No

Special Instructions: _____. I understand that if I have caller ID, the counselors name will be disclosed to others. Please Initial _____

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

*Please be aware that email might not be confidential.

Birth Date: ____/____/____ Age: _____ Gender: [] Male [] Female

Marital Status: [] Never Married [] Partnered [] Married [] Separated [] Divorced [] Widowed

Number of Children: _____ Ages: _____

Referred by: _____

Current reason for seeking therapy: _____

(Fill out this section if client is a minor)

- MINOR CLIENT-

Name of parent/guardian:

(Last) (First) (Middle Initial)

Parents are: (circle) Married Separated Divorced In process of divorce
Never Married

In the event of parents' separation and/or divorce, the court has set the following custody stipulations:

Physical Custody: (circle) mother father * full shared other

Legal Custody: (circle) mother father * full shared other

Legal Guardianship: relationship _____ documents _____

Have you had previous psychotherapy? No Yes

Previous therapist's name _____

Are you currently taking prescribed psychiatric medication (antidepressants or others)?

Yes No if yes, please list: _____

If no, have you been previously prescribed psychiatric medication?

Yes No if yes, please list: _____

HEALTH AND SOCIAL INFORMATION

1. How is your physical health at present? (Circle)

Poor Unsatisfactory Satisfactory Good Very good

2. Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.):

3. Are you having any problems with your sleep habits? No Yes

If yes, check where applicable: Sleeping too little Sleeping too much

Poor quality sleep Disturbing dreams Other _____

4. How many times per week do you exercise? _____

Approximately how long each time? _____

5. Are you having any difficulty with appetite or eating habits? No Yes

If yes, check where applicable: Eating less Eating more Binging Restricting

Have you experienced significant weight change in the last 2 months? No Yes

6. Do you regularly use alcohol? No Yes
 In a typical month, how often do you have 4 or more drinks in a 24-hour period? _____
7. How often do you engage recreational drug use? Daily Weekly Monthly Rarely N/A
8. Have you had suicidal thoughts recently? Frequently Sometimes Rarely Never
 Have you had them in the past? Frequently Sometimes Rarely Never
9. Are you currently in a romantic relationship? No Yes
 If yes, how long have you been in this relationship? _____
 On a scale of 1-10, how would you rate the quality of your current relationship? ____
 Do you currently feel safe in this relationship? No Yes
10. In the last year, have you experienced any significant life changes or stressors?

Have you ever experienced?

Extreme depressed mood	yes/no	Wild Mood Swings	yes/no
Rapid Speech	yes/no	Extreme Anxiety	yes/no
Panic Attacks	yes/no	Phobias	yes/no
Sleep Disturbances	yes/no	Hallucinations	yes/no
Unexplained losses of time	yes/no	Unexplained memory lapses	yes/no
Alcohol/Substance Abuse	yes/no	Frequent Body Complaints	yes/no
Eating Disorder	yes/no	Body Image Problems	yes/no
Repetitive Thoughts (e.g., Obsessions)			yes/no
Repetitive Behaviors (e.g., Frequent Checking, Hand-Washing)			yes/no
Homicidal Thoughts	yes/no		
Suicide Attempt	yes/no		

OCCUPATIONAL INFORMATION:

- Are you currently employed? No Yes
 If yes, who is your current employer/position? _____
 If yes, are you happy at your current position? _____

Please list any work-related stressors, if any: _____

RELIGIOUS/SPIRITUAL INFORMATION:

- Do you consider yourself to be religious? No Yes
 If yes, what is your faith? _____
 If no, do you consider yourself to be spiritual? No Yes

SEXUAL HEALTH HISTORY:

- Are any of your current concerns related to your sexuality? No Yes

If yes, what are your concerns? _____

Do you have any current/past experiences with sexual abuse or trauma? No Yes

FAMILY MENTAL HEALTH HISTORY:

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following?

(Circle any that applies and list family member, e.g., Sibling, Parent, Uncle, etc.):

<u>Difficulty</u>	<u>Family Member</u>
Depression	yes/no
Bipolar Disorder	yes/no
Anxiety Disorders	yes/no
Panic Attacks	yes/no
Schizophrenia	yes/no
Alcohol/Substance Abuse	yes/no
Eating Disorders	yes/no
Learning Disabilities	yes/no
Trauma History	yes/no
Suicide Attempts	yes/no

OTHER INFORMATION:

What do you consider to be your strengths?

What do you like most about yourself?

What are effective coping strategies that you've learned?

What are your goals for therapy?

Therapy is really about having a good relationship with someone you can trust.

The best way for us to have a good relationship is to get to know each other. So, if you don't mind a few more questions let me get to know you:

FAVORITE THINGS:

What is your favorite movie? _____

What is your favorite song? _____

What is your favorite TV shows? _____

What is your favorite thing to do with your friends? _____

What are you really scared of? _____

What makes your really happy? _____

What do you think is the most important thing I should know about you?