Kim Comerford LLC

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|  |  |  |
| --- | --- | --- |
| **INTAKE FORM** | Date of Intake |  |

Please type only in the shaded fields. They’ll expand as you type, if you need more space.

# Personal Information

|  |  |  |  |
| --- | --- | --- | --- |
| Name |  | Ethnicity |  |
| Age |  | Date of Birth |  | Social Security # |  |
| Address |  |
| City |  | State |  | Zip Code |  |
| Home Phone |  | Work Phone |  |
| Cell Phone |  | Email |  |
| Employer |  |
| Occupation |  | Education (highest level) |  |

## If client is a minor

|  |  |  |  |
| --- | --- | --- | --- |
| Grade |  | School |  |

### Parent/Guardian information

|  |  |
| --- | --- |
| Name |  |
| Home Phone |  | Work Phone |  |
| Cell Phone |  | Email |  |
| Preferred means of contact |  |

# Referral Source

|  |  |
| --- | --- |
| Where did you get my name? |  |
| Who recommended you to therapy? |  |

# Family Information

## For adult clients:

### Spouse/Partner

|  |  |  |  |
| --- | --- | --- | --- |
| Name |  | Occupation |  |
| Age |  | Education |  |

### Children

|  |  |  |
| --- | --- | --- |
| **Name** | **Age** | **Grade** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

## For child clients, or adult client’s childhood family:

### Mother

|  |  |  |  |
| --- | --- | --- | --- |
| Name |  | Occupation |  |
| Age |  | Education |  |

### Father

|  |  |  |  |
| --- | --- | --- | --- |
| Name |  | Occupation |  |
| Age |  | Education |  |

### Siblings

|  |  |  |
| --- | --- | --- |
| **Name** | **Age** | **Grade** |
|  |  |  |
|  |  |  |
|  |  |  |

# Emergency Contact

|  |  |
| --- | --- |
| Name |  |
| Relationship |  | Phone |  |

# Medical Information

|  |  |
| --- | --- |
| Describe any health problems you have |  |
| What serious illnesses have you had? |  |
| List any prior surgeries |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Have you had prior counseling or therapy? |  | Yes |  | No |

|  |  |  |
| --- | --- | --- |
| If yes: | When? |  |
|  | What was the concern? |  |
|  | Who was/were your counselor(s)? |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Have you ever been given a mental health diagnosis in the past? |  | Yes |  | No |
| If yes: | What was the diagnosis? |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Have you ever been hospitalized for psychiatric treatment? |  | Yes |  | No |
| If yes: | For what reason? |  |
|  | Where? |  |
|  | For how long? |  |

## Current Information

Please list any medications that you currently take.

|  |  |  |
| --- | --- | --- |
| **Medication** | **Purpose** | **How long?** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

|  |  |
| --- | --- |
| What brings you to counseling now? |  |
| How long have your current problems existed? |  |

# Symptom List

Please check all that apply and circle your top 5 concerns.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | crying spells |  | fast heartbeat |  | money problems |
|  | unable to have fun |  | always worried |  | relationship concerns |
|  | feelings easily hurt |  | frequent sweating |  | work difficulties |
|  | lacking in confidence |  | Dizziness |  | sexual problems |
|  | Constipation |  | shaky hands |  | can’t hold a job |
|  | feeling grouchy |  | stomach trouble |  | excessive drinking |
|  | always tired |  | Nightmares |  | startles often/easily  |
|  | poor appetite |  | feeling tense |  | excessive drug use |
|  | Depressed |  | cold feet and hands |  | problems with children |
|  | trouble sleeping |  | feeling panicky |  | problems with parents |
|  | feeling lonely |  | Diarrhea |  | poor physical health |
|  | loss of weight |  | shy with people |  | fighting and quarreling |
|  | not enjoying things |  | muscle twitching |  | dislike my body |
|  | suicidal thoughts |  | nausea or vomiting |  | full of energy |
|  | feeling inferior |  | can’t make decisions |  | overly ambitious |
|  | loss of sexual interest |  | can’t make friends |  | easily excited |
|  | no one understands me |  | Headaches |  | quick tempered |
|  | worried about health |  | fainting spells |  | impatient with people |
|  | can’t concentrate |  | unable to relax |  | binge eating |
|  | can’t “get going” |  | feeling fearful |  | very restless |
|  | feeling angry |  | overly sensitive |  | want to hurt someone |
|  | feel like smashing things |  | anxious inside |  | don’t like being alone |
|  | lack energy |  | weight gain |  | excessive overeating |

## Describe your present state

Check one

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Mild |  | Moderate |  | Moderately Severe |  | Severe |  | A Crisis |

|  |  |
| --- | --- |
| Have you had suicidal thoughts? |  |
| Have you attempted suicide? |  |

Have you experienced any of the following? Please check off all that apply:

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | Neglect |  | Physical Abuse |  | Sexual Abuse |  | Domestic Violence |

Kim Comerford LLC

***INSURANCE INFORMATION***

|  |  |
| --- | --- |
| Date |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Client  |  | Phone |  |
| Age |  | Date of Birth |  | Social Security # |  |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Marital Status |  | Single |  | Married |  | Divorced | Other: |  |

|  |  |
| --- | --- |
| Address |  |
| City |  | State |  | Zip |  |

## If the policy holder address is different from the client address:

|  |  |
| --- | --- |
| Address |  |
| City |  | State |  | Zip  |  |
| Home Phone |  | Work Phone |  |

***Insurance Information:***

|  |  |
| --- | --- |
| Policy Holder’s Full Name |  |
| Date of Birth |  | Social Security # |  |
| Insurance Company |  |
| Member Number |  | Group Number |  |
| Employer/company |  | Relationship to Client |  |
| Insurance Co Address |  |
| City |  | State |  | Zip  |  |
| Phone # |  |

***Office Use Only:***

|  |  |
| --- | --- |
| Service  |  |
| DX # |  |
| Auth. # |  |