Link Therapy & Mediation
collaborate • connect • empower

For office use only:
Therapist:
DBT:
Dx Codes:
Intake Date/Time:

INTAKE FORM

Welcome to Link Therapy & Mediation. These forms will give you the chance to describe your story. Please fill them out as completely as possible and bring them with you to your first session. Please be aware that you may leave blank any part that you feel uncomfortable filling out at this time.

Basic Client Information

First Name: _____ Last Name:_____ MI: _____

Date of Birth: _____ Age: _____

Marital Status: Married Single Divorced Separated Partnered

(please circle) Engaged Cohabitating Divorce in Process Widowed

Employment Status: Employed (full/part) Unemployed Stay-at-home parent

Occupation: _____ Employer: _____

Student Status: Full-time Part-time School: _____ Not a student

What is your level of education? In school HS Grad/GED Vocational/Tech College/Graduate

Race/Ethnicity (optional): _____

Cultural heritage, if any (ex. Norwegian): _____

Religious Affiliation, if any (ex. Baptist): _____

Gender Identity: Male Female Transgendered (please specify): _____
Other (please specify): _____

Sexual Orientation: Heterosexual Gay Lesbian Queer
Other (please specify): _____

How did you hear about Link Therapy and Mediation? _____

Contact Information

Please understand we will use the address listed below for all communication we mail to your home, including billing statements. If you would like to make alternative arrangements with us regarding your mailing address, please do not hesitate to let your therapist know.

Address

City State Zip Code

Contact Methods		**Can we leave a message here?**	
Cell Phone		Yes	No
Home Phone		Yes	No
Work Phone		Yes	No
Email Address		Yes	No

What is your preferred method of communication?_____

Insurance and Billing Information

Primary Insurance Carrier

Insurance Carrier (ex. BCBS):	
Is your primary insurance through MA or MHCP (Minnesota Healthcare Programs): Y N	
Is your primary insurance through an employer? Y N	
ID Number:	Group Number:
Name of Policy Holder:	
Address of Policy Holder:	
City, State, Zip of Policy Holder:	
Date of Birth of Policy Holder:	
Social Security Number of Policy Holder:	
Policy Holder's Relationship to the Client (ex. self, spouse, parent):	

Secondary Insurance Carrier (if applicable):

Secondary Insurance Carrier (ex. MA):	
Is your secondary insurance through MA or MHCP (Minnesota Healthcare Programs): Y N	
Is your secondary insurance through an employer? Y N	
ID Number:	Group Number:
Name of Policy Holder:	
Address of Policy Holder:	
City, State, Zip of Policy Holder:	
Date of Birth of Policy Holder:	
Social Security Number of Policy Holder:	
Policy Holder's Relationship to the Client (ex. self, spouse, parent):	

Financial Guarantor (person responsible for payment)

The financial guarantor for an account is the person responsible for paying the bill. In most cases, this will be the client him/herself. If so, please fill in your own information. In other cases, someone else may be responsible. In that event, please fill in that person's information and have him/her sign below.

Name of Guarantor:	Date of Birth:
Address of Guarantor:	
City, State, Zip of Guarantor:	
Guarantor's Relationship to the Client (ex. self, spouse, parent):	

I understand I am solely responsible for any charges outstanding on the above client's account and accept responsibility for prompt payment of any outstanding balance.

Signature Printed Name Date

Personal Strengths

According to yourself and others, what are your best personal qualities? _____

What activities do you enjoy and feel you are successful when you try? _____

Describe your support system (people, activities that calm you, stabilizing beliefs/values).

Reason for Seeking Counseling

Briefly describe the reason you have decided to try counseling at this time. _____

What would you like to see happen or change as a result of counseling? _____

In general, how confident are you that the counseling process could be helpful?

Please circle: Not confident A little confident Somewhat confident Very confident

If you could give your therapist advice on how to be most helpful to you, what would you say?

Current Symptoms and Lifestyle

Are any of the spaces in your home unusable because of the amount of clutter in them? Y N

Do any of the members of your family have a problem with this? _____

Are you a smoker? Y N

If yes, how much do you smoke in a 24-hour period? _____

If yes, are you interested in resources to help you quit at this time? Y N

Have you ever, or do you currently, engage in self-injurious behavior, like cutting? Y N

If yes, are you willing to share the last time you did? _____

Do you ever have thoughts about ending your life? Y N

If yes, have you made a previous attempt? Y N

If yes, do you have a current plan you are considering acting on? Y N

Are you the victim of or abuse or bullying in any of your current relationships? Y N

Is there anyone you are considering physically harming? Y N

Symptom	Not at all	Some days	1/2 the days	More than 1/2 the days	Nearly every day	For how long?
Ex. Sadness/Depression					x	6 months
Sadness/Depression						
Crying						
Sleep Disturbances						
Increased/decreased appetite						
Increased/decreased weight						
Low self-worth						
Low energy/motivation						
Hopelessness						
Unresolved anger						
Loss of Interest in normal activity						
Low productivity/creativity						
Decreased sex drive						
Irritability						
Suicidal Thoughts						
Loneliness						
Grief/Loss						
Unresolved guilt						
Memories of trauma/flashbacks						
Nightmares						
Dissociation						
Mood swings						
Racing Thoughts						
Elevated Mood						
Feeling panicky/anxious						
Panic attacks						
Excessive worrying						
Disorganized						
Social anxiety						
Social isolation						
Specific phobias						
Paranoid thoughts						
Losing train of thought						
Hyperactivity						
Poor Concentration/indecisive						
Easily Distracted						
Impulsivity						
Obsessive Thoughts						
Compulsive Behaviors						
Cutting/self-mutilation						
Bingeing/Purging						
Over-exercising						
Hallucinations						
Spiritual Concerns						

Personal History

Do you commonly experience physical symptoms, such as headaches, nausea, etc? Y N

If yes, please explain: _____

_____

Do you have any medical conditions, such as chronic pain, disabilities, etc? Y N

If yes, please explain: _____

_____

Have you ever been in treatment for mental health or substance abuse? Y N

If yes, what kind of treatment? _____

If yes, when did treatment occur? Y N

Have you ever been hospitalized for a mental health concern? Y N

If yes, what were the circumstances? _____

If yes, what were the approximate dates? _____

Have you ever been to counseling or therapy before? Y N

If yes, what were the circumstances (reason, with whom, etc)? _____

_____

_____

If yes, are you willing to share the provider? _____

If yes, what were the approximate dates? _____

Do you have a previous mental health diagnosis that you know of? Y N

If yes, what is it? _____

If yes, what was **least** helpful about the experience? _____

If yes, what was **most** helpful? _____

Have you misused drugs or alcohol in the past? Y N

If yes, please explain: _____

_____

Have you ever taken medication for a mental health concern? Y N

Medication	Dates Taken	Helpful? (yes or no)

Do you have military experience? None Previous Currently Serving Direct Combat History

To the best of your knowledge, was your mother's pregnancy with you normal? Y N

To the best of your knowledge, was your early development (milestones, etc) normal? Y N

Are there any legal issues presently affecting you or your family? Y N

If yes, please explain: _____

_____

_____

Relationship and Family History

Family of Origin (family you grew up in)

Please tell us about anyone you considered to be a part of your family when you were growing up.

Name	Age Now	Sex	Relationship	Lives with you (Y/N)
Ex: Johnny	59	M	Step-father	Saw him 2 days/week

What word would you use to describe your family of origin? _____

What is your birth order (ex. oldest, only)? _____

How old were you when you left home and what were the circumstances (ex. moved in with a friend at 22, went to college at 18)?

_____

_____

_____

Did/does any member of your family have significant issues we should be aware of (ex. chemical dependency, mental illness, disabilities, legal trouble, etc)?

_____

_____

_____

Did you/do you now have significant issues with anyone in your family or origin?

_____

_____

_____

Do/did any members of your family of origin have significant issues with each other?

_____

_____

_____

Describe whatever you feel comfortable sharing about abuse, if any, you experienced in your family of origin (that impacted you and/or any other family member).

_____

_____

_____

_____

_____

_____

Current Family

Please tell us about anyone you consider to be a part of your family now, not including those mentioned above.

Name	Age Now	Sex	Relationship	Lives with you (Y/N)
Ex: Jill	32	F	Partner/Spouse	Yes

Total number of marriages: _____

What word would you use to describe your current family? _____

Although the first three items refer to marriage, please think of your relationship with your current (or recent) partner, whether you are married or not, as you answer the questions (please circle answers). Please use the following scale to rate your answers:

1 = Extremely Dissatisfied 4 = Neutral 7 = Extremely Satisfied

1. How satisfied are (or were) you with your relationship? 1 2 3 4 5 6 7
2. How satisfied are (or were) you with your relationship with your partner?
1 2 3 4 5 6 7
3. How satisfied are (or were) you with your partner as a partner? 1 2 3 4 5 6 7

Have you experienced any abuse in your adult life (emotional, verbal, physical, sexual)? If so, please describe whatever details you feel comfortable sharing at this time.

_____

_____

Please check any of the following family concerns you are experiencing/have experienced:

Concern	Current	Childhood	Concern	Current	Childhood
Death of a family member			Fighting		
Health problems of family member			Alcohol/drug use of a family member		
Disagreeing about relatives			Feeling Distant		
Disagreeing about friends			Lack of honesty		
Parental overprotection			Physical Fights		
Inadequate housing or unsafe neighborhood			Educational issues		
Inadequate health insurance or access to healthcare			Financial problems		
Divorce/Separation			Infidelity		
Job Change/Dissatisfaction			Remarriage		

_____ _____

Client Signature Date

_____ _____

Parent/Guardian Signature (if applicable) Date