LOWCOUNTRY FAMILY & CHILDREN INTAKE FORM:

This intake form is to help me acquire some basic demographic about you or your child and allow me to get a better understanding of your reason for seeking services. It is just a BRIEF screening tool and can be updated as needed during our time together. For parents of children, fill this out as if you were answering it FOR your child. Your information can go in the emergency contact section. Please call me at 843 494 8756 or email me at david@lowcountryfc.com if you have any issues or concerns.

Demographic Information:

Date: _____

Legal Name: _____ Preferred Name: _____

Phone: _____ Voice Messages OK (Y/N)? _____

Email: _____

Address: _____

DOB: ___/____/ ____

Occupation (or School/Grade): _____

How did you find out about us? _____

Emergency Contact:

_____ (Initials) **I agree that Lowcountry Family & Children may contact this person in case of emergency.**

Name: _____ Relationship: _____

Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Client Questions

All answers will be kept confidential, except in cases of threat of harm to self or others, known or suspected child or elder abuse, or court order**.**

- **Have you ever received a mental health diagnosis?** __ Yes __ No

  If yes, what was it? _____

- **Have you ever taken medications for a mental health or emotional issues?**
  __ Yes __ No

  If yes, what was it? _____

  _____

- **Have you ever been hospitalized for mental health or emotional reasons?** __ Yes __ No

- **Have you ever had an eating disorder or compulsive habit (gambling, shopping, etc.)**
  __ Yes __ No

- **Have you ever had any thoughts about harming yourself or others?**
  __ Current/Recent thoughts __ Past thoughts __ Never

- **Do you have any legal issues right now?** __ Yes __ No

_____

- **Are you currently pregnant (for women)?** __ Yes __ No

_____

Alcohol and Drug Use: (If you are a parent filling out for a small child, and this is not applicable, please just answer "NA")

1. Any history or current use/abuse of alcohol?

_____

2. Any history or current use/abuse of illegal drugs or prescription medication?

_____

Depression:

1. Over the past six months have you experienced a **2-week** period of time where you have felt down, depressed, or hopeless? __ Yes __ No

2. Over the past six months have you experienced a **2-week** period of time where you have felt little interest or pleasure in doing things? __ Yes __ No

Anxiety:

Over the past **two weeks**, how often have you been bothered by the following problem (circle one number).

1. Feeling nervous, anxious, on edge?

   0 Not at all _____

   1 Several days _____

   2 More than half the days _____

   3 Nearly every day _____

2. Not being able to stop or control worry?

0 Not at all _____

1 Several days. _____

2 More than half the days. _____

3 Nearly every day. _____

Brief summary of treatment goals:

In a paragraph or two, please give a brief overview of what it is you hope to accomplish during your time in therapy. Please do not feel overwhelmed by this process, as it will be discussed in much better detail and explored further overtime:

_____

_____

_____

_____

_____

_____

_____