TRYSHA LM BODDEN, LMFT, LLC
1130 N. Nimitz Hwy. Suite A-203
Honolulu, HI 96817
Phone (808) 294-5810 Fax (808) 441-7744

CLIENT INTAKE FORM

(To be completed by client)

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) (Middle Initial)

Name of parent/guardian (if under 18 yrs.):

_____

(Last) (First) (Middle Initial)

Birth Date: _____/_____/_____ Age:_____ Gender:_____

Marital Status: □Single □Married □Divorced □Separated □Widowed □Domestic Partnership

Please list any children/age:_____

Address:_____

(Street and Number)

_____

(City) (State) (Zip)

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

Cell/other Phone:_____ May I leave a message? □Yes □No

Emergency Contact:_____

(Name) (Phone) (Relationship to client)

May I leave a message? □Yes □No

E-mail address: _____May I email you? □Yes □No

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

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INSURANCE INFORMATION

Who is responsible for the bill? ☐Patient ☐Insurance*

Name of Physician: _____ Telephone: _____

Primary Insurance Carrier: _____Membership #: _____

Name of Subscriber: _____

Date of Birth of Subscriber: _____ Relationship to Subscriber:_____

Secondary Insurance Carrier: _____Membership #: _____

Name of Insured: _____

Date of Birth of Subscriber: _____ Relationship to Subscriber:_____

*Please provide your Insurance Card

Referral source—who referred you to my office or how did you learn about my practice?_____

THERAPEUTIC HISTORY

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

□No

□Yes (briefly describe reason, date & length of treatment):_____

_____

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

Please list: _____

_____

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Have you ever been prescribed psychiatric medication? □Yes □No

Please list & provide dates:_____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION:

1. How would you rate your current physical health? (please circle)

   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 do 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? Briefly describe: _____

   _____

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

   If yes, when did you begin experiencing this? Briefly describe:_____

   _____

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

   If yes, please describe_____

8. Do you drink alcohol? □Yes □No If yes, approximately how many drinks/week do you have?_____

9. How often do you engage in recreational drug use?

   □Daily □Weekly □Monthly □Infrequently □Never

10. Are you currently in a romantic relationship? □Yes □No

    If yes, for how long?_____

    Current partner's name_____

    On a scale of 1-10 how would you rate your relationship?_____

11. What significant life changes or stressful events (if any) have you experienced recently?

FAMILY MENTAL HEALTH HISTORY:

In the section below, identify if there is a family history of any of the following by circling "yes" or "no". If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.)

Alcohol/Substance Abuse	yes/no	_____
Anxiety	yes/no	_____
Depression	yes/no	_____

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Domestic Violence	yes/no	_____
Eating Disorders	yes/no	_____
Obesity	yes/no	_____
Obsessive Compulsive Disorders	yes/no	_____
Schizophrenia	yes/no	_____
Suicide Attempts	yes/no	_____

ADDITIONAL INFORMATION:

1. Are you currently employed? □Yes □No

Occupation_____ Employer_____

Do you enjoy your work? Is there anything particularly stressful about your current work?

_____

_____

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?

   _____

   _____

   _____

   _____

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4. What do you consider to be some of your weaknesses?

_____

_____

_____

_____

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

_____

_____

_____

_____

ASSIGNMENT AND RELEASE: I hereby consent and authorize to have Trysha Bodden, of Trysha LM Bodden, LMFT, LLC, to make any and all insurance claims on my/our behalf. I also authorize the therapist named above to release any information required to the insurance carrier. I understand that I am financially responsible for all charges whether covered by insurance or not.

Signature: _____ Date: _____

If authorization is provided by a personal representative of the patient, please describe relationship to patient/authority status to provide authorization:_____

For Office Use Only: ☐Insurance Card Copied ☐HIPAA Form Signed