Beautiful Mind Therapy, Inc
Phone: 708-695-4808 Fax: 888-965-7017
975 East Nerge Road, Suite W40, Roselle, IL 60172-4809

BEAUTIFUL MIND
THERAPY

Adult/Child Intake Assessment

The information asked for below is to help me work with you. Please fill out this form as completely as you can. All information will be held in strict professional confidence unless otherwise directed by law.

Intake information: **Date:**

First Name: Middle Name: Last Name:
_____

DOB: Gender:
_____ _____
Home Address:
_____
City State Zip
_____
Home phone number: Cell number: Work number:
_____

Would you like to receive e-mail notifications from us? If yes, please provide your e-mail:
_____

Emergency Contact: Phone: Relationship:
_____

Referring source: ☐ Psychology Today ☐ Google ☐ Friend/coworker name: _____
☐ Doctor's name: _____ ☐ Other_____

Insurance information: Self-Payment: Yes ☐ No ☐ Insurance: Yes ☐ No ☐
If "Yes" complete below

Name of insured:
First Name: Last Name: Relationship:
_____
DOB: Social Security number:
_____ _____

Insurance ID number: Group number:
_____ _____
Insured place of employment:
_____
Name and phone of insurance:
_____
Insurance Address:
_____
City State Zip

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Presenting Concerns

Why are you seeking treatment at this time?

_____
_____
_____

When did your current symptoms/issues begin?

_____
_____

What stressors may have contributed to the current complaint or problem?

_____
_____

Primary Concerns (check all that apply):

___ Depressed/sad/feeling down
___ Loss of interest in activities
___ Can't seem to enjoy myself
___ Feeling unhappy about myself
___ Crying spells
___ Difficulty enjoying things
___ Loneliness
___ Trouble sleeping/nightmares
___ Poor Appetite
___ Trouble concentrating
___ Tiredness
___ Procrastination/difficulty making decisions
___ Feeling guilty
___ Feelings of helplessness
___ Feelings of hopelessness
___ Feelings of worthlessness
___ Low self-esteem
___ Thoughts about death
___ Suicidal thoughts/plans
___ Homicidal thoughts/plans
___ High/low energy
___ Racing thoughts
___ Angry/irritable
___ Hearing voices, seeing things that are not there
___ Paranoid thoughts
___ Anxiety
___ Excessive worry
___ Panic attacks
___ Repetitive thoughts
___ Rituals
___ Perfectionism
___ Trouble socializing/making friends
___ Feeling rejected by others
___ Difficulty expressing feelings
___ Difficulty saying "No" to others
___ Interpersonal difficulties with men/women
___ Difficulties with children
___ Interpersonal difficulties with parents
___ Roommate/friendship difficulties
___ Marital problems
___ Problems with work/school
___ Financial problems
___ Chronic/terminal illness
___ Loss of loved one
___ Sexual problems
___ Use of alcohol
___ Use of drugs
___ Addictions (Internet, porn, shopping, gambling)
___ Preoccupation with food, diet, or exercise
___ Feelings of loss of control over eating
___ Dissatisfaction with my appearance body
___ Restricting food
___ Binging/purging behaviors
___ Self-harm/cutting/burning yourself

What are you hoping to accomplish from coming to therapy?

_____
_____

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Treatment History

Outpatient treatment history (therapist, coach, day program, partial hospitalization program):

Where: Dates attended: Frequency of visits:

What did you like/dislike about previous therapy?

What did you learn about yourself through previous therapy that may help you?

Is there any type of treatment you would like to continue?

Inpatient psychiatric hospital treatment history:
Where: Dates of treatment:

Substance abuse treatment history (Rehab, Intensive Outpatient Program, Partial Hospitalization, Halfway House, Recovery House, Counseling, Methadone, Suboxone):
Where: Dates of treatment:

Psychotropic medications:
Present medications: Dosage & frequency: Side Effects:

Past medications: Dosage & frequency: Side Effects:

Current Psychiatrist: Contact Information:

Current Physician: Contact information:

Pharmacy: Contact information:

Do you have any conditions/disabilities that I need to be aware of (seizures, head injury, etc.)?

If you use alcohol or drugs that are not prescribed, please list how much and frequency:

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Childhood/Social History

Did you meet normal developmental milestones (walking, talking, reading, school, career, etc.)?

_____
_____

What was it like growing up in your home?

_____
_____
_____

What was relationship like with your parents/guardians/siblings?

_____
_____

Do you have a family history of psychiatric illness/addiction (diagnosis, hospitalizations, suicide)?

_____
_____

Trauma History

Have you ever experienced the death of someone you cared about?

_____

Have you ever experienced physical, emotional, or sexual abuse or neglect?

_____
_____

Have you ever been a victim of a violent crime such as assault, mugging, rape, etc.?

_____
_____

General information

What are your living circumstances?

_____

What is your marital status?

_____

Do you have any children?

_____

What is your highest education completed?

_____

Do you currently have any pending criminal charges/probation?

_____

What do you do to relax and unwind?

_____

What are your strengths?

_____

What are your weaknesses?

_____

What are your long-term goals?

_____