Restorative Integration

613 Kimbark Street, Longmont, CO 80501
720-938-8715 • www.restorativeintegration.com

Intake Form

Client's name: _____ Date: _____

Address: _____

City, State: _____ Zip: _____

Email: _____

Phone numbers: ***Please check next to the phone number you prefer us to use.***

Home: ( )_____ ☐ Can we leave a message? ☐ Yes ☐ No

Work: ( )_____ ☐ Can we leave a message? ☐ Yes ☐ No

Cell: ( )_____ ☐ Can we leave a message? ☐ Yes ☐ No

Birth date: _____ Age: _____

Sexual Orientation (optional): Bisexual❑ Gay/Lesbian❑ Heterosexual❑ Uncertain ❑

Employer/School_____

Position/Grade: _____

Marital/relationship status: _____ Significant other's name: _____

Significant other's age and sex: _____ How long together? _____

Names and ages of family members: _____

_____

How do you spend your free time?_____

_____

Who are major supports in your life: Parent(s) ☐ Friend(s) ☐ Sibling(s) ☐ Other ☐
Child(ren) ☐ Relatives☐ Professional Caregiver(s)☐ Partner/Spouse☐
Pet(s) ☐ What kind?_____ Religious/Spiritual Community☐ _____

How did you hear about Restorative Integration or Amanda Mahan?_____

Who shall we contact in case of emergency?

Name: _____Phone ( )_____

How will you be paying for your sessions? ☐ Cash ☐ Check ☐ Credit Card

What is your preferred time for treatment? _____ How often?_____

What do you expect from your treatment? _____

_____

_____

What brings you to Restorative Integration?

_____

_____

_____

_____

What forms of services do you seek/have interest in?
Psychotherapy/Counseling ☐ DBT ☐ Conflict Resolution ☐ Psycho-Education ☐

Meditation/Awareness Instruction ☐ Personal Development ☐ Life Coaching ☐

Are you currently receiving, or have you previously received services from a counselor/ mental health professional (i.e. psychiatrist, therapist, life coach)? Yes ☐ No ☐

If yes, please list provider name, contact information and dates of treatment:
Provider_____
Address_____ Phone_____-_____-_____
Dates of Treatment_____

Provider_____
Address_____ Phone_____-_____-_____
Dates of Treatment_____

Have you ever been hospitalized for emotional or drug/alcohol treatment? Yes ☐ No ☐
If yes, please describe the circumstances of hospitalization:

_____

_____

Please list any medications you are currently taking:

_____
(medication) (dose) (how often) (prescribed by) (reason prescribed)

_____
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_____
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_____
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Please indicate which of these substances you currently use:

Substance	**Amount used**	**How often?**
Cigarettes		
Alcohol		
Pills not prescribed for me		
Marijuana		
Cocaine or crack		
LSD		
Heroin		
Other (please list):		

Please indicate if you are having any of the following problems, or if you had them in the past by rating them using the following scale: (now= in the past 2 weeks)

1- Serious Problem 2- Moderate Problem 3- Minor Problem 4- Not a problem

	now	past
Difficulty falling asleep or staying asleep	_____	_____
Sleeping too much	_____	_____
Change in appetite, weight loss, or weight gain	_____	_____
Frequent crying	_____	_____
Panic attacks or anxiety attacks	_____	_____
Thoughts of killing or hurting myself	_____	_____
Attempts to kill or hurt myself	_____	_____
Problems concentrating	_____	_____
Problems remembering things	_____	_____
Periods of daily sadness lasting more than two weeks	_____	_____
I startle easily	_____	_____
Can't stop remembering upsetting past events	_____	_____
Difficulty controlling my temper	_____	_____
I physically hurt other people	_____	_____
I break things sometimes	_____	_____
I worry a lot	_____	_____
Little or no interest in sex	_____	_____
I feel tired almost every day	_____	_____
Feelings of unreality	_____	_____
Made myself throw up in order to lose weight	_____	_____
Used laxatives or exercised excessively to lose weight	_____	_____
I often feel like I am an outsider	_____	_____
Sexual problems	_____	_____
Frequent arguments with the people I live with	_____	_____
Physical Pain (please specify)	_____	_____