DR. HOVI SHROFF

SOUTH FLORIDA COUNSELING ASSOCIATES

INTAKE FORM

Please provide the following information and answer the questions below.

Please note: information you provide here is protected as confidential information.

Name: _____

(FIRST) (LAST) (MI)

Name of Parent/Guardian (if under 18 years):

_____

(FIRST) (LAST) (MI)

Birth Date: _____ /_____ /_____ **Age**: _____

What Gender Do You Identify With: _____

Address:

_____City_____Zip_____

Home Phone: ( ) **May We Leave a Message?** □ Yes □ No

Cell/Other Phone: ( ) **May We Leave a Message?** □ Yes □ No

Relationship Status:

□ Never Married □ Domestic Partnership □ Married □ Separated□ Divorced □ Widowed

Please list any children/age: _____

E-mail: _____ **May We Email You?** □ Yes □ No

Please note: Email and text correspondence is not considered to be a confidential medium of communication

Emergency contact information:

Person/Relationship to Client: _____

Address/Phone#: _____

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

□ No □ Yes, previous therapist/practitioner:

_____

Are you currently taking any prescription medications? (PSYCH/MEDICAL)

□ Yes □ No Allergies if any?

Please list all: _____

Presenting problem/Reason for seeking counseling services:

_____

Have you undergone any trauma in the past or present? If yes, please explain:

_____

GENERAL PHYSICAL AND MENTAL HEALTH INFORMATION

1a. How would you rate your current physical health?

Poor Unsatisfactory Satisfactory Good Very good

1b. When did you have your last physical? _____

2. Please list any specific health problems/surgeries/cosmetic surgeries:

_____

3. How would you rate your current sleeping habits?

Poor Unsatisfactory Satisfactory Good Very good

_____

4. How many times per week do you generally exercise? _____

What types of exercise to you participate in? _____

5. Please list any difficulties you experience with your appetite or eating patterns

_____

6. Are you currently experiencing overwhelming sadness, grief or depression?

□No □ Yes- If yes, for approximately how long?

_____

7. Are you currently experiencing anxiety, panic attacks or have any phobias?

□No □ Yes-If yes, when did you begin experiencing this?

_____

8. Are you currently experiencing any chronic pain?

□No □ Yes-If yes, please describe/ medications if any:

_____

9. Do you drink alcohol? Yes/No

□ Daily □ Weekly □ Monthly □ Infrequently □ Never

How Much? _____

10. How often do you engage recreational drug use? □

Daily □ Weekly □ Monthly □ Infrequently □ Never

How Much? _____

11. How often do you smoke or chew tobacco?

□ Daily □ Weekly □ Monthly □ Infrequently □ Never

How much? _____

12. Has anyone such as your family or friends expressed concern for your change in behavior with regards to the following: State No/Yes

a) Alcohol b) Drugs c) Gambling d) Tobacco e) Caffeine use f) Domestic violence/Anger

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

If yes, for how long? _____

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

14. What significant life changes or stressful events have you experienced recently or in the past?

_____

PERSONAL/FAMILY HISTORY:

In the section below identify if **you or a family member** has a history of any of the following.

If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

Kindly rate <u>severity</u> on a scale of 1-10, 1 being mild and 10 being extremely severe.

Please identify Yourself /Family Member:

Alcohol/Substance Abuse:

Yes/No/Frequency/Amount/Duration/Severity

_____

Anxiety:

Yes/No /Duration/ Severity_____

Depression:
Yes/No/Duration/Severity_____

Domestic Violence:

Yes/No/Duration/Severity_____

Sexual /Physical/Emotional Abuse:

Yes/No/Duration/Severity _____

Eating Disorders:

Yes/No/ Duration/ Severity _____

Weight Gain or Loss

Yes/No/ Duration/ Severity _____

Obsessive Compulsive Behavior:

Yes/No/ Duration/ Severity _____

Cognitive/Memory Problems:

Yes/No/Duration/Severity _____

Suicidal or Homicidal Ideations/Attempts:
Yes/No_____

History of self-inflicted behaviors:
Yes/No_____

How do you identify yourself culturally/ethnically?

White Black Asian Hispanic Multi-Cultural

Employment Information:

Are you currently employed? Yes/No

If yes, what is your current employment situation?

_____

Do you enjoy your job?

_____

Are you currently facing any stressors at work?

_____

How do you get along with your co-workers/supervisors?

_____

Describe your early childhood experiences/school/college?

_____

Have you ever/currently been involved in a legal issue?

_____

Have you ever been incarcerated?

_____

What do you consider to be your strengths?

_____

What do you consider to be your weakness?

_____

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

_____

Print Name: **Signature:** **Date:**

_____

(By typing my name on this line, I acknowledge that this acts as my electronic signature and agreement to the above-mentioned terms)

Driver's License #_____

Expiration_____

Referred by (if any): _____

PAYMENT INFORMATION:

I agree to pay the sum of $200.00 per session to:

Dr. Hovi Shroff (South Florida Counseling Associates):

Cash/Check**:** _____

Credit Card #_____ Exp._____ CVV #_____

Signature of Client_____ **Date:** _____

(By typing my name on this line, I acknowledge that this acts as my electronic signature and agreement to the above-mentioned terms)

Insurance information:

Type of Insurance: _____ **Policy #:** _____

Secondary Insurance: _____**Policy #:** _____