FRANCO PSYCHOTHERAPY

Franco Bejarano, LCSW · Francopsychotherapy.org
Francopsychotherapy@gmail.com · 470. 491.3753
Atlanta, GA 30310

Confidential Intake Form

PERSONAL INFORMATION:
My name is: _____ Date:_____
Pronouns: _____
Address: _____
City: _____ Zip Code: _____
Home Phone: _____ Email: _____
Cell Phone: _____
May we call? Y/N Leave messages? Y/N
Date of birth: _____ Age: _____
I currently live with:_____
Relationship(s) to me:_____
Languages spoken: _____
I am here because:

My strengths are:
_____
My interests are:
_____
Gender: ☐ male ☐ female ☐ mtf ☐ ftm ☐ queer ☐ other:_____
My sexual orientation is: ☐ Heterosexual ☐ Bisexual ☐ Gay ☐ Lesbian ☐ Queer ☐ other:
_____
Emergency Contact: _____ Phone: _____
Relationship to Emergency Contact Person: _____
How did you hear about Franco Psychotherapy? _____

MENTAL HEALTH HISTORY:
Previous therapy counseling (when with whom):
_____
Do you have developmental challenges? (Ex: Autism, learning disability, childhood disabilities):
_____
Any mental health issues (list and describe, previous diagnoses, including any course of treatment):
_____
Psychotropic Medications currently used (name, dosage, length of time taking it, side effects experienced):
_____
_____
Psychotropic Medications previously used (name, dosage, length of time taking it, side effects experienced):

_____

_____

Current Psychiatrist (name, address, #): _____

Last psychiatric hospitalization: _____

Medical issues: _____

Any history of attempts or thought about suicide or wanting to hurt other people. If so, when:

_____

Have you ever been diagnosed with a substance abuse disorder, has you past or current use of substances have created problems in your life? ☐ Yes ☐ No If Yes, please explain:

_____

VOCATION (fill out for parents if under 18):

I am employed: ☐ Yes ☐ No My title is: _____

I am employed with: _____

I have worked there for: _____

Salary per year/month: _____

My job has been impacted by my presenting concerns: ☐ Yes ☐ No If Yes, please explain:

_____

PRESENTING CONCERNS:

Reason seeking therapy:

_____

Are you experiencing any symptoms that have been a concern for more than four weeks and get in the way of you living life? ☐ Yes ☐ No If Yes, please list which symptoms:

_____

Check all that apply:

☐ Low energy
☐ Low self-esteem
☐ Poor concentration
☐ Thoughts of suicide
☐ Hopelessness
☐ Loneliness
☐ Worthlessness
☐ Depressed
☐ Isolation
☐ Sadness/loss
☐ Thoughts of hurting yourself
☐ Guilt
☐ Don't like weekends and vacations
☐ Sleep disturbance
☐ Appetite disturbance
☐ Stress
☐ Thoughts of hurting someone else
☐ Anxiety/panic
☐ Heart pounding/racing
☐ Chest pain
☐ Trembling/shaking
☐ Chills/hot flashes
☐ Tingling/numbness
☐ Fear of dying
☐ Fear of going crazy
☐ Nausea
☐ Phobias
☐ Racing thoughts
☐ Obsessions/compulsive behaviors
☐ Headaches
☐ Palpitations
☐ Bowel disturbances
☐ Nightmares
☐ Feel tense
☐ Unable to relax
☐ Can't make friends
☐ Can't keep a job
☐ Financial problems
☐ Excessive sweating
☐ Dizziness
☐ Stomach trouble
☐ Fatigue/exhaustion
☐ Take sedatives
☐ Feel panicky
☐ Conflict

☐ Sexual problems
☐ Spousal abuse concerns
☐ Blaming others
☐ Overambitious
☐ Inferiority feelings
☐ Excessive use of drugs
☐ Memory problems
☐ Fainting spells
☐ Excessive use of prescription medications
☐ Reproductive concerns
☐ Alcoholism
☐ Blackouts
☐ Insomnia
☐ Shy with people
☐ Avoiding others
☐ Tremors

☐ Unable to have a good time
☐ Crying spells
☐ Allergies
☐ Can't make decisions
☐ Paranoia/distrust
☐ Home conditions bad
☐ Easily startled
☐ Eating concerns (binging, purging, restricting)
☐ Concentration difficulties
☐ Self criticism
☐ Mood fluctuations
☐ Work problems
☐ Not thinking clearly/confusion
☐ Feel out of control

☐ Excessive drinking
☐ Delusions/hallucinations ☐ Self injury
☐ Can't hold onto an idea
☐ Feeling that you are not real
☐ Excessive behaviors (spending, gambling)
☐ Lose track of time
☐ Feeling that things around you are not real
☐ Anger/frustration
☐ Unpleasant thoughts that won't go away
☐ Easily agitated/annoyed
☐ Defying rules

Other:
_____

HISTORY:
I have been involved with the legal system: ☐ Yes ☐ No If Yes, please explain:
_____
Are you seeing a therapist required/recommended by the courts/attorney: : ☐ Yes ☐ No

Are you now experiencing, or have you ever experienced, any of the following events? If yes, please list age of occurrence, by whom, and whether the event occurred once or more.
❑ Yes ❑ No Physical assault or abuse: _____
_____
❑ Yes ❑ No Sexual assault or abuse: _____
_____
❑ Yes ❑ No Emotional or verbal abuse: _____
_____
❑ Yes ❑ No Parental neglect: _____
_____
❑ Yes ❑ No Domestic violence: _____
_____
❑ Yes ❑ No Violent crime: _____
_____
❑ Yes ❑ No Participating in or witnessing combat: _____
_____
❑ Yes ❑ No Ritual abuse or torture: _____
_____
❑ Yes ❑ No Other Traumas (please list):_____
_____

I hereby certify that the content disclosed within these pages is accurate and complete to the best of my knowledge.

_____

Client Signature Date