Anna Kris Bell, MA, UP
Ph: 970-682-3270
Email: kris@invcmc.com
www.invcmc.com

INNER VOICE
MINDFUL CHOICE

Client Intake Form ____/____/_____

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

Please fill out the form below and bring it to your next session or mail it to Inner Voice Mindful Choice, Kris Bell, 1506 Mount Meeker Ave, Berthoud, CO 80513. Thank you!

Basic Information

Name: _____
(First, Middle initial, Last)

Birthdate: _____/_____/_____ Age: _____ Gender: **( )** Male **( )** Female

( ) Other gender affiliation (please specify how you would like to be addressed. _____)

Address: _____
(Street & Number)_

_____
(City) (State) (Zip)
Home Phone: (_____) _____ May I leave a message? ( )Yes ( )No

Cell/Other Phone: (_____) _____ May I leave a message? ( )Yes ( ) No

Email: _____ May I send you email? ( ) Yes ( ) No

Emergency Contact

Name: _____ Phone: _____

Relationship to you: _____

Please explain your reasons for seeking assistance and your goal to the best of your ability.

Marital Status:

( ) Never Married **( )** Domestic Partnership **( )** Separated

( ) Widowed **( )** Married **( )** Divorced

On a scale from 1 to 10 (10 as best) how would you rate your relationship?

_____

Please list any children and their ages:

Please list any lethal weapons you own and how you store them:

General Physical & Mental Health Information

Have you previously received any type of mental health services (psychotherapy, counseling, psychiatric services, etc.)? If so, who was the practitioner and when did you receive these services?

_____

Referred by (if applicable) or How did you find out about me?

_____

Physician or PCP's name: _____

If you are on any medications, please list them here:

_____

_____

_____

Have you ever been prescribed psychiatric medication (including anti-depressants)? If yes, please list them here:

_____

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

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems that you are currently experiencing:

_____

_____

_____

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:

_____

_____

How often are you able to exercise and what type of exercise suits you?

_____

Do you: (please circle)

Drink alcoholic beverages (including beer or wine) Smoke Cigarettes

Use Medical Marijuana Imbibe in Recreational Drug Use

Please describe your choices of substances to imbibe and frequency for each:

_____

Pain: (If Pain is one of your reasons for seeking assistance please use the following area to describe your experiences. If not, please skip this area.)
Is your ability to exercise limited due to pain? If yes, please describe your limitations to the best of your ability:

_____

_____

Are you experiencing chronic pain (pain lasting longer than 6 months)? If yes, please describe the type of pain, dis-ease or injury. Include estimates of average pain levels based on the 1-10 scale (10 being the worst imaginable pain).

_____

_____

_____

Weight and Body Acceptance. If this is one of your reasons for seeking assistance please use the following area to describe your experiences. If not please skip this area.)
Do you struggle with accepting how you look in the mirror or in photographs? Do you feel governed by a scale?

_____
_ Please describe any difficulties you experience with appetite or eating patterns (use extra paper if necessary):

_____

_____

Are you currently experiencing overwhelming sadness, grief, or depression? If yes, for how long and to what do you attribute the emotions?

Are you currently experiencing anxiety, panic attacks, or have any phobias that inhibit your ability to enjoy life? If yes, please describe to the best of your ability:

Family Health History

In the section below, identify if there is a family 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.).

List Family Member

Alcohol/Substance Abuse . . . . . _____
Anxiety . . . . . _____
Depression . . . . . _____
Domestic Violence . . . . . _____
Eating Disorders . . . . . _____
Obesity . . . . . _____

Obsessive Compulsive Behavior . . . . . _____
Schizophrenia . . . . . _____
Bi-Polar Disorder . . . . . _____
Suicide Attempts . . . . . _____

I have answered the questions above truthfully and to the best of my knowledge.

_____ **Date** _____
(client signature)