Unlimited You, LLC

Lucinda Testo, MS, LPC
350 Silas Deane Highway Suite #303
Wethersfield, CT 06109
860-759-8703

CLIENT DEMOGRAPHIC AND INTAKE FORM

Client Name: _____ **Date:** _____

Date of Birth: _____ **Age:** _____

Address: _____

Phone: (Cell) _____ **Can a confidential message be left?** Yes or No

Is texting ok? Yes or No

(Home) _____ **Can a confidential message be left?** Yes or No

Email: _____

Marital/Relationship Status: _____

Race/Ethnicity/Religious Affiliation (Optional): _____

Profession, if applicable: _____

School/Grade: _____

Insurance Information

Primary Insurance Provider: _____ **Secondary Insurance Provider:** _____

Insured's Name: _____ **Insured's DOB:** _____

ID #: _____ **Group #:** _____

Claims Address: _____

Provider Services Phone Number: _____ **Copay Amount:** _____

Emergency Contact Information

Name: _____ **Relationship:** _____ **Phone:** _____

Primary Care Physician: _____ **Phone:** _____

Current Medications/Doses: _____

Prescriber Name: _____ **Phone:** _____

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Presenting Concern: (Briefly state current concerns, symptoms, behaviors, etc.)

_____
_____
_____
_____

What are stressors that could be contributing to your current situation? (Relationship, work/school, financial, etc.)

_____
_____
_____

How have these concerns affected your currenting functioning: (Home, work, school, interpersonally)

_____
_____
_____

What are your goals/hopes/dreams?

_____
_____
_____

What are your strengths/interests/passions?

_____
_____
_____

Who are your supports?

_____
_____
_____

What are three things that you would like to work on in counseling?

_____
_____
_____

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SYMPTOMS/CONCERNS:

(*checking or circling items does not indicate a diagnosis)*

☐**Yes**☐**No** **DEPRESSION** (sad, irritable, hopeless, poor sleep, crying, social, withdrawal, spends time alone, lack of interest or motivation, ect.)

☐**Yes**☐ **No** **MOOD SWINGS** (energetic, little sleep, pleasure-seeking, racing thoughts/talkative, inappropriate sexual behaviors, grandiose=feeling able to accomplish anything/without limits, inflated self-esteem, etc.)

☐**Yes** ☐**No** **ANXIETY** (worries, restless, specific fear of:_____, scared, poor sleep, compulsive behaviors, frequent complaining of headaches and/or stomach aches, frequent school absences, etc.)

☐**Yes** ☐**No** **BEHAVIORAL PROBLEM** (fights, anger, arguing, truancy, destroys property, fire setting, vindictive, cruel, bullies others, lies, etc.)

☐**Yes** ☐**No** **ATTENTION/HYPERACTIVITY PROBLEM** (difficulty paying attention, hyperactive, impulsive, interrupts, difficulty completing tasks, poor concentration, needs constant reminders, ect.)

☐**Yes** ☐**No** **ABNORMAL EATING BEHAVIORS** (too much, too little, fear of weight gain, distorted body image, over exercising, etc.)

☐**Yes** ☐**No** **SOCIAL ANXIETY** (shy and/or afraid to be around others)

☐**Yes** ☐**No** **REMEMBERING PAST TRAUMAS** (frequent nightmares, intrusive and/or recurrent memories, avoiding situations that are reminders of the trauma, over-reactive to certain situations, etc.)

☐**Yes** ☐**No** **PSYCHOSIS** (hearing voices, seeing things, paranoia, delusions, odd ideas, unusual fantasies, etc)

☐**Yes** ☐**No** **DISSOCIATION** (feeling outside your body or things are not real, etc.)

☐**Yes** ☐**No** **SUICIDAL/HOMICIDAL -Has the client ever harmed themselves or another person intentionally? Attempted suicide? Threatened harm? Current ideation? (explain):**_____

Anything else you would like to tell me:

_____

_____

_____

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