BLOOM

Client Information / Intake Form

Please complete the following, use the back if you require additional space

Name: ____ Date:__________________
(Last) (First) (Middle Initial) (Preferred Name)

Birth Date: _______/_______/_______ Age:_________ Gender:__________________

Relationship Statues: ☐ Never Married ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Address: ____
(Street) (city) (State) (Zip)

Phone:_____________________________ Email:_____________________________________

Ok to leave messages: *YES / NO*

Referred by?____

Are you currently employed? ☐ No ☐ Yes, Who is your employer & position held ______________________
____

Are you currently in school? ☐ No ☐ Yes, Where: ____

What is the most stressful thing in your life right now?____
____

Briefly state the nature of the problem: ____
____
____

What do you want to gain from counseling? ____
____
____

Circle any of the following that are supportive influences in your life:

Extended family	Friends	Faith based support	Community resource
Doctor	Employer	Child care	Other counselor or therapist
School/Educational system		Other: ______________________	

Please list your strengths: ____
____

Are you **currently** receiving any kind of counseling or mental health services elsewhere?

☐No ☐Yes, Where & with whom?____

Have you had **previous** mental services or counseling of any kind?

☐ No ☐ Yes, With whom & dates:____

Are you **currently** taking any prescription medication?

☐ No ☐ Yes, Please list the name, The dosage & for what purpose: ___________________________
____

Prescribed by:_________________________________May I consult with this prescriber? ☐ Yes ☐ No

Have you been **previously** prescribed psychiatric medication (i.e. Antidepressant)?

☐ No ☐ Yes, Please list:____

Primary Doctors Name:____

If I need, may I consult with your Doctor? ☐ No ☐ Yes, Phone____________________________________

Have you ever been hospitalized for mental illness? ☐ No ☐ Yes, Please Explain ______________________
____

Average number of alcoholic drinks consumed per week: ____________

Do you smoke? ☐No ☐ Yes, how often? ______________________ What substance? ______________________

Do you currently or have you ever abused drugs, including prescription?

☐ No ☐ Yes, please explain: ____

<u>How often</u> ***have you experienced the following problems*** **recently*?***

	Not at all	Hardly ever	Yes sometimes	Yes often
I have felt little interest or pleasure in things	☐	☐	☐	☐
I have felt down, depressed, or hopeless	☐	☐	☐	☐
I have been sleeping too much	☐	☐	☐	☐
I have had poor appetite or been over eating	☐	☐	☐	☐
I have felt bad about myself / felt like a failure	☐	☐	☐	☐
I have felt like I've let myself &/or my family down	☐	☐	☐	☐
I have had trouble concentrating on things	☐	☐	☐	☐
I have felt fidgety or restless	☐	☐	☐	☐
I have had thoughts that I would be better off dead	☐	☐	☐	☐
The thought of harming someone else has occurred to me	☐	☐	☐	☐

<u>In the past 7 days</u> ***how frequently have you experienced the following?***

	Not at all	Hardly ever	Yes sometimes	Yes often
The thought of harming myself has occurred to me	☐	☐	☐	☐
I have felt scared or panicky	☐	☐	☐	☐
I have been so miserable that I have been crying	☐	☐	☐	☐
Things have been too much for me to cope with	☐	☐	☐	☐
I have blamed myself unnecessarily when things went wrong	☐	☐	☐	☐
I have had trouble falling asleep or staying asleep	☐	☐	☐	☐
I have been able to laugh & see the funny side of things	☐	☐	☐	☐
I have looked forward with enjoyment to things	☐	☐	☐	☐
I have been anxious or overly worried	☐	☐	☐	☐
I have felt sad or miserable	☐	☐	☐	☐

<u>How bothered</u> ***have you been*** **recently** ***by the following problems?***

	Not bothered	Bothered a little	Bothered a lot
Worrying about your health	☐	☐	☐
Your weight or how you look	☐	☐	☐
Little or no sexual desire or pleasure during sex	☐	☐	☐
Difficulties in relationship with partner / spouse	☐	☐	☐
Difficulties in relationship with others (i.e. Family / Friends)	☐	☐	☐
The stress of taking care of children, parents, or other family	☐	☐	☐
Stress outside your home (i.e. Work / School)	☐	☐	☐
Financial problems or worries	☐	☐	☐
Something bad/ upsetting happened	☐	☐	☐
Having no one to turn to when you have a problem	☐	☐	☐
Thinking or dreaming about something bad that happened in your past	☐	☐	☐

For women Only:

Which best describes your menstrual periods?

☐ Periods are unchanged

☐ No periods because pregnant or recently gave birth

☐ Irregular or changed in amount, frequency, or duration

☐ No period for at least a year

☐ Having periods & taking HRT or oral contraceptives

During the week prior to your period starting, do you notice problems with your mood?
(i.e. depression, anxiety, irritability, anger or mood swings) ☐ No ☐ Yes

How many times have you been pregnant: ________How many children are you parenting? _________________

Live Births: #__________ Date(s):____

Abortions: #__________ Date(s):____

Loss/Miscarriages: #__________ Date(s): ____

Are you having difficulty getting pregnant? ☐ No ☐ Yes

Have you received treatment for infertility? ☐ No ☐ Yes, date(s): ____________________________________

Please mark the following items you experienced <u>growing up to present</u>

☐ Physical abuse – by whom? _______________________________________ When?_______________

☐ Emotional abuse – by whom?______________________________________ When?_______________

☐ Sexual abuse – by whom?____ When?_______________

☐ Loved one die – who?____ When?_______________

☐ Serious medical problem – what?___________________________________ When?_______________

☐ Alcoholic parent(s) – who? ____

☐ Drug abusing parent(s) – who?______________________________________

☐ Depressed parent(s) – who? ____

☐ Parent with emotional problems – which? ______________________________

☐ Parents separated / divorced – when?_________________________________

☐ Felt neglected or unloved – by whom?_________________________________

☐ Learning difficulty – what?____

☐ Attempted suicide – when?____

☐ Unhealthy childhood?____

☐ Frequent moves?____

☐ Legal problems?____

Client signature: ____ Date:_____________________

Provider signature: ____ Date:_____________________

Perinatal Information

Please complete the following regarding your pregnancy, delivery and baby.
Please use the back if you require additional space.

Baby's Name____ Date of Birth/ Due date:______________________

Birth: ☐ Vaginal ☐ C-Section ☐ Induction ☐ Epidural

Birth Weight ______________________ How many weeks was baby at birth? ____________________________

Where did you deliver or plan to deliver? ____

Who is your OB/ Midwife(s) during this pregnancy? ____

Who is delivering/ delivered your baby? ____

How are you feeding your baby? ____

Please list any medical complications you or your baby may have had during pregnancy, Delivery, or postpartum. Include month of pregnancy or postpartum when it occurred.

____
____
____
____

Any emotional difficulty during this pregnancy? Include month of pregnancy when occurred.

____
____
____
____

Have you had any prior miscarriages, loss of pregnancy, or loss of a child? Please give dates and length of pregnancy or age of child. ____
____

If you have other children:

Child 1- Name: ________________________________ Age:_______ Date of birth:_________________________

Birth: ☐ Vaginal ☐ C-Section ☐ Induction ☐ Epidural

Birth Weight ______________________ How many weeks was baby at birth?______________________________

Feeding: ☐ Breast, age weaned_____ ☐ Bottle ☐ Other: _________________________________

Please list any emotional difficulty and / or medical complications you or your baby may have had during pregnancy, delivery, postpartum. Include month pf pregnancy or postpartum when it occurred.

____
____
____

Child 2- Name: ________________________________ Age:_______ Date of birth:_________________________

Birth: ☐ Vaginal ☐ C-Section ☐ Induction ☐ Epidural

Birth Weight ______________________ How many weeks was baby at birth

Feeding: ☐ Breast, age weaned_____ ☐ Bottle ☐ Other:_________________________________

Please list any emotional difficulty and / or medical complications you or your baby may have had during pregnancy, delivery, postpartum. Include month pf pregnancy or postpartum when it occurred.

____
____
____

Child 3- Name: ________________________________ Age:_______ Date of birth:_________________________

Birth: ☐ Vaginal ☐ C-Section ☐ Induction ☐ Epidural

Birth Weight ______________________ How many weeks was baby at birth

Feeding: ☐ Breast, age weaned_____ ☐ Bottle ☐ Other:_________________________________

Please list any emotional difficulty and / or medical complications you or your baby may have had during pregnancy, delivery, postpartum. Include month pf pregnancy or postpartum when it occurred.

____
____
____