Chane Reaction LLC

Counseling Services

Linking You To Resources For A Better Tomorrow

Clinical Intake Form
(Please print and fill out the form)

Insurance Provider: _____ . Please email a copy of your photo identification and your insurance card to your assigned therapist or upload a photocopy of both documents to your therapy portal account. This will help us to verify that you are covered for mental health services and to determine co-payments, (if applicable), before your first appointment.

THIS FORM MUST BE PRINTED, COMPLETED, AND UPLOADED TO YOUR THERAPY PROFILE BEFORE YOUR INTAKE APPOINTMENT

The following questions are designed to provide your therapist with important information regarding your life history. This information will assist the therapist in providing you with specialized treatment to ensure you are achieving optimal health. Thank you for taking the time to complete this form. If you have any challenges with completing this questionnaire or uploading the requested documents, please reach out to your therapist.

Today's Date:

First and Last Name: _____

DOB: _____

What's bringing you into therapy?

What are your goals for treatment?

1.)
2.)
3.)
4.)
5.)

Employment:

Are you currently employed? If yes, please provide your place of employment below. (on the next page)

Name of Business**:** _____

Your Title: _____

Full-Time or Part-Time: _____

Education Background:

Year In High School: _____

Year In College: _____

Post College Degree: _____

Marital Status: (Circle one that applies)
Single
In a relationship
Never Married
Married
Divorced
Separated

Sexual Orientation:
Heterosexual
Bi-Sexual
Homosexual
Asexual

Pansexual

Race/Ethnicity:
Black
White
Asian
Hispanic
Latino
Latinx

Living Situation:
Independently
Roommate
Parents
Partner
Friend

Siblings:
1
2
3
4

Other:

Psychiatric Hospitalization:
Do you have a history of psychiatric illness or hospitalizations? If yes, When and where?

Date:_____

Location: _____

Length of time: _____

Past History of Mental Health Treatment:

Date(s): _____

Location: _____

Therapist:_____

Psychiatric Medications:

Name of Medication(s): _____

Dose: _____

Prescribing Physician: _____

Medical Concerns:

Do you have a history of surgical procedures? If yes, please explain below:

Primary Care Physician:

Do you have a primary care physician? If yes, please provide their name and place of employment below.

Name:

Place of Employment:

Current Medications:

Are you currently taking medications that are not treating psychiatric illnesses? Ex: High blood pressure, Asthma, etc

Substance Use:

Do you have a history of substance use? If yes, please identify your drug of choice and the length of time you have been using below.

Drug Of Choice :_____

Daily Amount:_____

Route of Administration:_____ ex: oral, I.V.

Age of First Use: _____

Date of Last Use:_____

Treatment History:_____

Family History of Dependency/Psychiatric illnesses:

Do you have a family history of psychiatric illness? If yes, please explain below.

Spirituality:

Are you currently affiliated with any spiritual practice? If yes, please explain below.

Suicidal or Homicidal Ideations:

Do you have a history of suicidal thoughts, self-harm, or a desire to harm another person? If yes, please explain below.

This document is for clinical use only. The information provided will not be disclosed to any third parties.