



**South Charlotte Counseling and Psychotherapy,  
PLLC**

Jumana S Scoggins, MA, NCC, LCMHC

**CLIENT INTAKE FORM**

Please provide the following information for our records. This information will remain confidential. Please print out this form and bring it to your first session.

Name: \_\_\_\_\_  
(Last) (First) (Middle Initial)

Name of parent/guardian (if you are a minor):

\_\_\_\_\_  
(Last) (First) (Middle Initial)

Birth Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age: \_\_\_\_ Gender:  Male  Female

Marital Status:

Never Married  Partnered  Married  Separated  Divorced  Widowed

Address: \_\_\_\_\_

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Home Phone: ( ) \_\_\_\_\_ May we leave a message?  Yes  No

Cell/Other Phone: ( ) \_\_\_\_\_ May we leave a message?  Yes  No

E-mail: \_\_\_\_\_ May we email you?  Yes  No

\*Please be aware that email might not be confidential.

Emergency Contact: \_\_\_\_\_ Phone : ( ) \_\_\_\_\_

Referred By: \_\_\_\_\_

Are you currently receiving psychiatric services, professional counseling or psychotherapy elsewhere?  Yes  No

Have you had previous psychotherapy?  Yes  No

Previous therapist's name \_\_\_\_\_

Are you currently under a physician's care?  Yes  No

List of current medications (prescription and non-prescription):

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### HEALTH AND SOCIAL INFORMATION

1. How is your physical health at present? (please circle)

Poor                  Satisfactory                  Good                  Excellent

2. Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.):

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3. Are you having any problems with your sleep habits?  N  Y

If yes, check where applicable:

Sleeping too little  Sleeping too much  Poor quality sleep  Disturbing dreams  
 Other \_\_\_\_\_

4. How many times per week do you exercise? \_\_\_\_\_

5. Do you regularly use alcohol?  N  Y

How much? \_\_\_\_\_

6. Do you use drugs?  N  Y

7. Have you had suicidal thoughts recently?  Frequently  Sometimes  Rarely  
 Never

Have you had them in the past?  Frequently  Sometimes  Rarely  Never

8. Are you currently in a romantic relationship?  N  Y  
If yes, how long have you been in this relationship? \_\_\_\_\_

On a scale of 1-10, how would you rate the quality of your current relationship?  
\_\_\_\_\_

9. In the last year, have you experienced any significant life changes or stressors:

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**Have you ever experienced:**

Extreme depressed mood:  N  Y

Body Image Problems:  N  Y

Wild Mood Swings:  N  Y

Repetitive Thoughts (e.g., Obsessions) :  
 N  Y

Extreme Anxiety:  N  Y

Repetitive Behaviors (e.g., Frequent  
Checking, Hand-Washing) :  N  Y

Panic Attacks:  N  Y

Hallucinations:  N  Y

Homicidal Thoughts:  N  Y

Alcohol/Substance Abuse:  N  Y

Suicide Attempt:  N  Y

**OCCUPATIONAL INFORMATION:**

Are you currently employed?  N  Y

If yes, who is your current employer/position?  
\_\_\_\_\_

If yes, are you happy at your current position?  
\_\_\_\_\_

Please list any work-related stressors, if any:  
\_\_\_\_\_

**RELIGIOUS/SPIRITUAL INFORMATION:**

Do you consider yourself to be religious?  N  Y

If yes, what is your faith?  
\_\_\_\_\_

If no, do you consider yourself to be spiritual?  N  Y