Debbie G. Ramirez, LCSW

8055 W Manchester Ave., Ste 450
Playa Del Rey, CA 90293
(310) 704-6854
www.latinxwellness.com

INDIVIDUAL CLIENT INTAKE FORM

Please provide the following information for our records. Leave blank any question you would rather not answer.

First Name_____ Last Name_____

Age_____ Birth Date_____ Sex/Gender _____ Race _____

Religion/Spirituality Practice _____

Marital Status (check all that apply)

☐ Married ☐ Widow ☐ Divorced ☐ Legally Separated ☐ Separated but living together ☐ Cohabitation ☐ Single

Number of children _____ Ages of children _____

Home Address/City/Zip _____

Who do you live with? _____

Mobile/Contact Number (_____)_____

Email_____ Preferred Method of Contact: ☐ email ☐ text/call

Emergency Contact_____ Relationship_____

Emergency Contact Phone Number (___)_____

EMPLOYMENT INFORMATION

☐ On sick leave, as of this date _____ Return to work date _____

I was ☐ Full-time or ☐ Part-time at _____ Position: _____

☐ Full-time at: _____ Position: _____

☐ Part-time at: _____ Position: _____

☐ Not working because: _____

PSYCHIATRIC AND MENTAL HEALTH TREATMENT HISTORY

Psychiatrist Name: _____ Frequency of sessions:_____

Address: _____ Telephone: (_____)_____

Have you ever been hospitalized for psychiatric reasons?

□ Yes □ No If yes, please describe when and where you were hospitalized, and for which reasons.
_____
_____

Please list any mental health diagnosis and any prescribed medication for diagnosis.
_____

Have you participated in individual counseling before?

Yes☐ No☐ If yes, with whom:_____

Where_____

Dates of treatment_____

Was the outcome successful? □ Very □ Somewhat □ No change □ Got worse

Reason for treatment: _____

FAMILY MENTAL HEALTH HISTORY

Has anyone in your family, either immediate family members or relatives, experienced difficulties with the following?

☐Depression	☐Bipolar Disorder	☐Anxiety Disorder	☐ Panic Attacks
☐Schizophrenia	☐Alcohol/Drug Abuse	☐Eating Disorders	☐Trauma History
☐Learning Disabilities	☐Suicide Attempts/ Completions	☐Other: _____	

MEDICAL HISTORY
How is your physical health at present? Circle one.

Poor Unsatisfactory Satisfactory Good Very Good

Date of last physical exam: _____ Date of last dental exam: _____

Primary Care Physician Name: _____

Address: _____ Telephone: (____) _____

Please list any medical or physical problems that you have been diagnosed with:

_____

Please list any medications you currently take, and what you take them for:

_____

HEALTH AND SOCIAL INFORMATION
Please describe your current habits in each of the following areas.

Caffeine Intake	
Drinking	
Drug Use	
Eating	
Exercise	
Fun and Relaxation	
Gambling	
Sleeping	
Smoking	

To what degree do you have family or friends that support you? Circle one

Extremely High Very High High Moderate Low Very Low Extremely Low

Are you in a romantic relationship? Yes☐ **No**☐

If yes, how long have you been in the relationship? _____

What is your level of satisfaction in your relationship? Circle one.

1 2 3 4 5 6 7 8 9 10

(not satisfied) (very satisfied)

Have either you or your partner struck, physically restrained, used violence against or injured the other person?

Yes☐ No☐ If yes for either, who, how often and what happened?

_____

_____

SIGNIFICANT OR STRESSFUL LIFE EVENTS

Please note any past or current significant and/or stressful life events that you have been experiencing.

Stressor:	Yes	No	If yes, please describe briefly:
Changes in appetite/eating			
Cultural issues			
Economic difficulties			
Educational/occupational			
Family conflict or lack of support			
Grief or Bereavement			
Housing			
Legal issues or crime			
Sleep disturbances			
Social problems			
Trauma history			
Weight gain or loss			
Other			

What is your current level of stress overall? Circle one:

1 2 3 4 5 6 7 8 9 10

(no stress) (high stress)

What areas in your life are causing you the most stress? (#1 being the most problematic).

1._____

2._____

3._____

Do you drink alcohol or take drugs to intoxication? Yes☐ No☐

If yes, how often and what drugs or alcohol are consumed?

_____

Do you ever wish you could cut back on your drinking or drug use? Yes☐ No☐ N/A☐

Have you sought treatment or are currently in treatment due to drug or alcohol use?

Yes☐ No☐ N/A☐ Currently in Treatment☐ In Recovery☐ _____months ____years

LEGAL INFORMATION

Have you ever been the victim of a crime? Yes☐ No☐ If yes, list date and briefly describe.

Are you currently involved in divorce or child custody proceedings? Yes☐ No☐ If yes, please explain.

Are you currently involved in any court or criminal proceedings? Yes☐ No☐ If yes, please explain.

Have you ever been convicted of a misdemeanor or felony? Yes☐ No☐ If yes, please explain.

TREATMENT INFORMATION

What are your treatment objectives (check all that apply)

☐ Improve Communication	☐ Problem Solving	☐ Conflict Resolution
☐ Increase Social Contacts	☐ Power and Control Issues	☐ More Hobbies
☐ Parenting Skills	☐ Resolve Individual Issues	☐ More Autonomy

☐ Other (specify) _____

What are effective coping strategies that you've used?

What do you consider to be your strengths/what do you most like about yourself?