SAMSKARA HEALING
PSYCHOTHERAPY & YOGA OFFERINGS

Lauren Jacobs, LCSW-R (518) 328-4741

INTAKE FROM

Please note that all information in this form is kept confidential per our services contract.

Client Contact Information

Name:(First)_____(Last)_____
Address:_____
email Address:_____
Date of Birth:_____ Gender:_____ Preferred Pronoun:_____

Phone Number:_____
It is okay to leave a message at this number (circle one): Yes No
It is okay to text this number (circle one): Yes No

Alternate Number:_____
It is okay to leave a message at this number (circle one): Yes No
It is okay to text this number (circle one): Yes No

How did you hear about me? _____

Emergency Contact Information
Please note, I will only contact this person in the event of an emergency and will always inform you if I do so.
Name:_____
Phone Number:_____
Alternate Number:_____

About You
Insurance Company_____
Insurance Company Contact # _____
ID# _____
Group # (if applicable)_____
My copay/coinsurance is $_____ per session
My deductible is: _____ I **have/have not** met my deductible (circle one)

Hobbies/Interests:_____

Reason for contacting me about starting therapy:
_____
_____
_____
_____

Goals you want to accomplish in working together:

_____

_____

Family History

Currently in a significant romantic relationship? Yes No

Significant prior relationship (divorced, widowed, etc.)? Yes No

Number of children and ages (if applicable):_____

Dependent adults living with you (if applicable): Yes No

If yes, list relationship:_____

Who currently lives in your home (list all that apply)?_____

_____

_____

Pets? Yes No

If yes, list name and type (dog, cat, etc.):_____

Employment/Education History

Job Title:_____ Current Employer:_____

Employment concerns (if applicable):_____

_____

_____

Degree (if applicable): _____

Current level in school (if applicable):_____

Educational concerns (if applicable):_____

_____

_____

Medical History

Primary Care Physician:_____

Date of most recent physical exam:_____

Current medications taken on a regular basis:

_____

_____

Please list any current medical problems (thyroid disorder, cancer, etc):

_____

_____

_____

_____

Please list any significant medical history (cancer, accidents, surgeries, etc.):

_____

_____

_____

_____

Please list any accommodations needed (wheelchair access, etc.):

_____

Mental Health Treatment History
Have you been in therapy before? Yes No
If yes, when and for how long? _____
Previous therapist(s) name(s):_____
Reasons for previous therapy:_____
_____
_____

Substance Use History
Please list any *current* substance use (alcohol, cigarettes, marijuana, etc.):
_____
_____
_____
_____
Frequency of use for above substances listed: Daily Weekly Monthly
Please list any *prior* substance use (alcohol, cigarettes, marijuana, etc.):
_____
_____
_____
_____
Are you currently in a substance abuse program or support group (circle one)? Page 4

Other
Religious/Spiritual Identification:_____
_____
Healthy Habits/Coping Styles
_____
_____
_____

Please list any other information not listed on this form that you feel is pertinent to my working with you:
_____
_____
_____
_____
_____
_____