

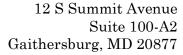


(301) 281-6550 | roni@apricity.sprucecare.com

Helping people focus on the Light when the shadow feels overwhelming.

Client Intake Form

Today's Date	-	
Personal Information		
Name: First	_ Last:	
Nickname:	_ Birth Date://	
Gender: \Box Female \Box Male \Box Transgender	r □ Non-binary □ Prefer to se	lf-describe:
Sexual Orientation:	_ Relationship Status:	
Military Service: □Yes □ No / Branch		_ Active: \square Yes \square No
Ethnicity:	Religion/Spirituality	:
Education Status: (Current or highest gra	ade/degree completed)	
Occupation:		
Home Address:		
City:	State:	_ Zip:
Home Phone ()	Cell Phone ()	
List each member of your household (nan	ne, age, and relationship to yo	ou): [on next page]



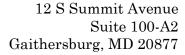


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Counseling Information
Primary reason for counseling services (briefly describe):
When did the reason indicated for seeking counseling begin?
\square within 30 days \square within 6-12 months \square within 2 years \square during adolescence \square during childhood
What areas of your life have been affected because of this problem?
What would you like to accomplish in our time together?
Any current or past thoughts of suicide or self-harm?
Any thoughts of harming others or homicide?
Were you referred by? \square Medical Provider $\square Mental \ Health \ Professional \ \square Spiritual \ Leader$
\Box Insurance Provider \Box Psychology Today \Box Friend/Family $\ \Box$ Other:
Have you previously received any type of mental health service? \square Yes \square No
If yes, please list previous counseling or psychiatric care you received below:
Counselor/ Date of Service/ Reason care discontinued

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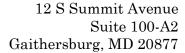


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III	
Any previous hospitalizations or day treati	ment programs?
Developmental History	
Please list any major events or concerns ab early, delayed, unknown, or anything rema	oout your (the client) developmental milestones (i.e., avera arkable/life changing/concerning):
Pregnancy and birth:	
Infancy:	
Childhood:	
Adolescence:	
"Adulting":	
Adulthood:	
Where were you born?	Where did you grow up?
Have you experienced any major losses, tra	auma, or traumatic experience? Yes No
Please list any family members and relation known:	onship to you with mental illness and/or substance abuse,

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Wellness Information Date of last physical exam:	Date of las	st dental exam:	
		Date of last annual:	
Have you had COVID-19? Yes No	Have you had the CC	OVID-19 vaccine? Yes No Date	
Any allergies? Please list:			
List any vitamin and vitamin supple	ments you take and how	7 often:	
List all current medications, including	ng over the counter medi		
Emergency Contact (full name/phone			
How would you characterize your over	erall health?		
How well are you sleeping? \Box Not sleeping	eeping \square Wake often \square U	Jnrestful \square Restful \square Energizing	
How many hours a day do you have s	screen time (all electron	ics)?	
How many times per week do you ge	nerally exercise?	How long do you exercise?	
What is your favorite beverage?	What is your dail	y caffeine intake?	
How often do you drink alcoholic bev	erages?	Use tobacco/e-cigarette/vape: $\Box Y \Box N$	
Use illegal drugs? \square Yes \square No Use m	arijuana 🗆 Yes 🗆 No Us	se medical marijuana 🗆 Yes 🗆 No	
Drug:	Route/method:	Last Taken:	
What do you enjoy doing in your free	e time/relaxing?		

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