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This confidential, multi-faceted, intake form helps us understand different parts and pieces to who you are as a person. Although some questions may seem irrelevant to your care, they will play a role in our core understanding of current and past issues and help us build and develop an integrative treatment plan.

Client Information

Today's Date: _____ Date of Birth: _____
Client Name: _____ Sex: M F
Address: _____ City: _____
State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____
Email Address: _____ May we email you? _____
Emergency Name and Contact Number: _____

Counseling Information

Please describe the difficulties you are having that have brought you to our office: _____

What has contributed to these difficulties? _____

What are your goals in seeking treatment at our office? _____

Have you been in treatment with a psychologist or psychiatrist before and if so for what? _____
_____ How long were you in treatment before: _____
What was the name of your prior counselor? _____
What else would be helpful for us to know: _____
Have you experienced any significant trauma or loss in your life, and if applicable, please indicate what and when: _____

What would you say is the main barrier(s) in allowing you live the life you desire? _____

How would you describe your life's purpose: _____

Please list 1-3 qualities, behaviors or characteristics that you would like to change or enhance within one year's time: _____

Employment Information

Employer: _____ Address: _____

Work Phone: _____ Occupation: _____

How would you rate your enjoyment of your job: (Low) 1 2 3 4 5 6 7 8 9 10 (High)

What about your job do you enjoy? _____

What about your job do you dislike? _____

What is your dream job? _____

Educational Background/Information

School: _____ School Address: _____

Date you graduated or expect to graduate: _____

What are you studying? _____

What are your educational goals? _____

Family Information

Marital Status: Single Married Divorced Separated Widowed Committed-Relationship

How many people live in your household: _____ Do you live with a roommate? _____

Do you have children? _____ If so, what are your children's names and ages? _____

Do you live in a group home or residential treatment center? _____

Are you part of a blended/step-family? _____

Will other friends or family members be participating in your counseling? _____

If so, who will be participating: _____

If you are in a romantic relationship, how would you rate your relationship with your partner?

(Low) 1 2 3 4 5 6 7 8 9 10 (High)

How would you rate your communication level with your partner?

(Low) 1 2 3 4 5 6 7 8 9 10 (High)

How would you rate your communication level with other family members?

(Low) 1 2 3 4 5 6 7 8 9 10 (High)

Do you have any pets, and if so, what type? _____

Who would you indicate as the main person who supports you emotionally: _____

Health Information

Are you currently under the care of a physician for any medical issue(s), and if so, please indicate: _____

Are you currently taking any prescribed medications, and if so, what:

Have you ever been treated or hospitalized for a psychiatric condition, suicide, drug/alcohol/substance abuse issue? _____

Does anyone in your family have a mental or psychiatric condition? _____

Have you ever been diagnosed with Bi-Polar Disorder? If so, when? _____

How would you rate your energy level in the past 4 weeks?

(Low) 1 2 3 4 5 6 7 8 9 10 (High)

How would you rate your current physical health?

(Low) 1 2 3 4 5 6 7 8 9 10 (High)

How would you rate your current emotional health?

(Low) 1 2 3 4 5 6 7 8 9 10 (High)

How would you rate your general happiness and wellbeing?

(Low) 1 2 3 4 5 6 7 8 9 10 (High)

In the past 4 weeks how would you rate your ability in being able to relax?

(Low) 1 2 3 4 5 6 7 8 9 10 (High)

How would you rate your current stress level?

(Low) 1 2 3 4 5 6 7 8 9 10 (High)

What would you indicate are major stressors in your life? _____

What are some ways that you have found are effective in helping you relieve stress? _____

How well do you nourish yourself with healthy/balanced food?

(Low) 1 2 3 4 5 6 7 8 9 10 (High)

How well do you nourish yourself with love/laughter?

(Low) 1 2 3 4 5 6 7 8 9 10 (High)

How well do you nourish yourself with words of self-encouragement?

(Low) 1 2 3 4 5 6 7 8 9 10 (High)

How well do you nourish yourself with self-care?

(Low) 1 2 3 4 5 6 7 8 9 10 (High)

What was the last book you read? _____

Who are some of your favorite musicians: _____

What do you do to have fun? _____

Do you currently take any nutritional supplements, vitamins, herbals, essential oils:

Do you have any difficulty falling asleep or staying asleep? _____

About how many hours of sleep do you average per night? _____

Do you awaken from sleep feeling rested? _____

Do you participate in any type of exercise activity, and if so, what and how often? _____

Have you ever practiced Yoga? _____ If so, what was your experience like?

Have you ever practiced Meditation? _____ If so, what was your experience like? _____

If not, what are the barriers preventing you from meditating? _____

Do you think that meditation would help you with your current issue? _____

Depression/Anxiety Questions

In the past four weeks:

Have you had difficulty falling asleep or sleeping long? _____

Have you had an increase or decrease in appetite? _____

Have you had feelings of sadness, despair, sorrow? _____

Have you had excessive fatigue or lack of energy? _____

Have you had a lack of concentration or preoccupation with past or future life events?

Have you withdrawn from socialization and contact with others? _____

Have you felt a decrease in activities that were previously enjoyable? _____

Have you had thoughts that you would be better off dead or hurting yourself in some way?

Have you had feelings like you were letting yourself or others down? _____

Have you had feelings of depression or anxiety? _____

Have you had worrisome thoughts and an inability to control your worry? _____

Have you had feelings of being afraid that something tragic might happen? _____

In the past month, how often have you been completely unable to manage your days and activities due to preoccupation with these feelings of distraction? _____

If you answered yes to any of the above questions, what have you tried to help yourself heal from these feelings? _____

What would you say is the major factor contributing to your feeling depressed or anxious?

When feelings of depression or anxiety come over you, where do you feel it in your body?

What do you think your body is trying to tell you? _____

Substance Abuse Information

Do you feel you have a substance abuse problem (alcohol, drug, other): _____

If so, what would you describe as your substance(s) of choice:

For how long have you struggled with this issue: _____

What is the longest you have voluntarily gone without abusing this substance: _____

Does anyone in your family have a substance abuse condition? _____

Spiritual Information

Do you feel connected spiritually? _____

What is your spiritual practice? _____

Mindfulness

FIVE FACET MINDFULNESS QUESTIONNAIRE (FFMQ)

Please rate each of the following statements using the scale provided. Write the number in the blank that best describes your own opinion of what is generally true for you.

1	2	3	4	5
Never or very rarely true	Rarely true	Sometimes true	Often true	Very often or always true

- 1. When I'm walking, I deliberately notice the sensations of my body moving.
- 2. I'm good at finding words to describe my feelings.
- 3. I criticize myself for having irrational or inappropriate emotions.
- 4. I perceive my feelings and emotions without having to react to them.
- 5. When I do things, my mind wanders off and I'm easily distracted.
- 6. When I take a shower or bath, I stay alert to the sensations of water on my body.
- 7. I can easily put my beliefs, opinions, and expectations into words.
- 8. I don't pay attention to what I'm doing because I'm daydreaming, worrying, or otherwise distracted.
- 9. I watch my feelings without getting lost in them.
- 10. I tell myself I shouldn't be feeling the way I'm feeling.
- 11. I notice how foods and drinks affect my thoughts, bodily sensations, and emotions.
- 12. It's hard for me to find the words to describe what I'm thinking.
- 13. I am easily distracted.
- 14. I believe some of my thoughts are abnormal or bad and I shouldn't think that way.
- 15. I pay attention to sensations, such as the wind in my hair or sun on my face.
- 16. I have trouble thinking of the right words to express how I feel about things.
- 17. I make judgments about whether my thoughts are good or bad.
- 18. I find it difficult to stay focused on what's happening in the present.
- 19. When I have distressing thoughts or images, I "step back" and am aware of the thought or image without getting taken over by it.
- 20. I pay attention to sounds, such as clocks ticking, birds chirping, or cars passing.
- 21. In difficult situations, I can pause without immediately reacting.
- 22. When I have a sensation in my body, it's difficult for me to describe it because I can't find the right words.
- 23. It seems I am "running on automatic" without much awareness of what I'm doing.
- 24. When I have distressing thoughts or images, I feel calm soon after.
- 25. I tell myself that I shouldn't be thinking the way I'm thinking.
- 26. I notice the smells and aromas of things.
- 27. Even when I'm feeling terribly upset, I can find a way to put it into words.
- 28. I rush through activities without being really attentive to them.
- 29. When I have distressing thoughts or images, I am able just to notice them without reacting.
- 30. I think some of my emotions are bad or inappropriate and I shouldn't feel them.
- 31. I notice visual elements in art or nature, such as colors, shapes, textures, or patterns of light and shadow.
- 32. My natural tendency is to put my experiences into words.
- 33. When I have distressing thoughts or images, I just notice them and let them go.
- 34. I do jobs or tasks automatically without being aware of what I'm doing.
- 35. When I have distressing thoughts or images, I judge myself as good or bad depending what the thought or image is about.

- 36. I pay attention to how my emotions affect my thoughts and behavior.
- 37. I can usually describe how I feel at the moment in considerable detail.
- 38. I find myself doing things without paying attention.
- 39. I disapprove of myself when I have irrational ideas.

Referral Information

Whom may we thank for referring you to our office:

Are you in our office for: Juvenile Court Referral Hospital Referral

Referral Employee Assistance Program Insurance Website
Psychiatrist Referral Psychologist Referral School Referral
Other: _____

Insurance Information

Name of Insured: _____
Relationship to you: _____
Date of Birth of Insured: _____
Insurance Name/Type: _____
Insurance Address: _____
Insurance Phone: _____
Insurance ID Number: _____
Group ID Number: _____

Credit Card Information

Please note we keep a credit card on file for no shows or for default in payment.

Credit Card Type: _____
Credit Card Code: _____
Credit Card Number: _____
Exp. Date: _____
Credit Card Name as it appears: _____

Client Name/Signature/Date

Client/Guardian Name:	Signature:
Date:	