Integrated Care Concepts & Consultation
New Jersey's Premier Mind/Body Service Provider

J. Larry Thompson
LCSW, Founder

Seth A. Arkush
MBA, LCSW, Partner

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.

Yoga and meditation practice do not replace the care from a therapist or medical provider, but rather is used in conjunction with care you receive with these providers to enhance your well-being.

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 else would be helpful for us to know:_____

_____

Employment Information

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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? _____
_____

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? _____
_____

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: _____
_____

Please describe any medical conditions or situations that have had in the past: _____
_____
_____

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Are you currently experiencing any pain in your body? _____

If so, please describe, where the pain is and the intensity: _____
_____
_____

What have you tried to help relieve the discomfort? _____
_____

Is there any other health condition you would like to share? _____
_____

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 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?

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(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)

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? _____
_____
_____

What would you indicate is a source of comfort for you in your life: _____
_____

What do you do to have fun? _____

What was the last book you read? _____

Who are some of your favorite musicians: _____

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 currently take any nutritional supplements, vitamins, herbs, essential oils: _____
_____

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

Have you ever practiced Yoga? _____ If so, what style did you practice? _____

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If you have practiced yoga , please describe your experience: _____

What are your goals and/or expectations in participating in a yoga and meditation practice?
_____

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

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

How do you think meditation might help you in your life? _____

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? _____

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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?_____

Spiritual Information

Do you feel connected spiritually? _____

What is your spiritual practice? _____

Referral Information

Whom may we thank for referring you to our office: _____

Read & Sign

Client/Guardian Name:	Signature:
Date:	