

# CLIENT CONTACT INFORMATION SHEET

**E. Noach Shapiro, LCSW**  
101 Park Street Suite 3,  
Montclair, New Jersey 07042  
enoachshapiro@gmail.com

Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_

Gender:

- Male  
 Female

Name: \_\_\_\_\_

Address (Street and Number): \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_-\_\_\_\_\_

May We Leave a Message

- Yes  
 No

Cell/Other Phone: (\_\_\_\_) \_\_\_\_-\_\_\_\_\_

May We Leave a Message

- Yes  
 No

E-mail:

May We Email You?

- Yes  
 No

\*Please note: Email correspondence is not considered to be a confidential medium of communication.

## Occupation:

Place of Employment: \_\_\_\_\_

Work Number: (\_\_\_\_) \_\_\_\_-\_\_\_\_\_

If needed, is it OK to call here?

- Yes  
 No

## Emergency Contact:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone Number: (\_\_\_\_) \_\_\_\_-\_\_\_\_\_

# CLIENT INTAKE FORM

**E. Noach Shapiro, LCSW**  
101 Park Street Suite 3,  
Montclair, New Jersey 07042  
enoachshapiro@gmail.com

Date of first appointment:

Please take your time in providing the following information. The questions are designed to help me begin to understand you so that our time together can be as productive as possible. All information provided is confidential.

Referred by:

- Medical Provider: \_\_\_\_\_
- Insurance Provider: \_\_\_\_\_
- My Website:
- PsychologyToday
- Friend/Family: \_\_\_\_\_
- Other: \_\_\_\_\_

Have you previously received any type of mental health services?

- Yes
- No

If yes, which of the following:

- Psychotherapy
- Medication
- Outpatient Hospitalizations
- Inpatient Hospitalization

If yes, please provide:

Name of provider or facility: \_\_\_\_\_

Location: \_\_\_\_\_

Dates of treatment: \_\_\_\_\_

Reason for treatment: \_\_\_\_\_

Briefly, what brings you in today

When did your problem first start? Within the last:

- 30 days
- 6--12 months
- 2 years
- During adolescence
- During childhood

What areas of your life have been affected because of this problem?

Are you currently experiencing overwhelming sadness, grief or depression?

- Yes
- No

If yes, for approximately how long? \_\_\_\_\_

Are you currently experiencing anxiety, panic attacks or have any phobias?

Yes

No

If yes, when did you begin experiencing this? \_\_\_\_\_

Please describe any major losses or traumas you have experienced:

What significant life changes or stressful events have you experienced recently?

What would you like to accomplish out of your time in therapy

### Family History

Where were you born? \_\_\_\_\_

Where did you grow up? \_\_\_\_\_

City

Suburbs

Country

Please list your parents and siblings. Please use additional space on the back if needed

**Name** **Age** **Relationship**

**Where do they live now?**

**If deceased, age and cause of death**

Who did you live with while growing up? \_\_\_\_\_

Mother's occupation: \_\_\_\_\_

Father's occupation? \_\_\_\_\_

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

Condition	Please circle	List Family Member
Alcohol/Substance Abuse	yes/no	
Anxiety	yes/no	
Depression	yes/no	
Domestic Violence	yes/no	
Sexual Abuse	yes/no	
Eating Disorders	yes/no	
Obesity	yes/no	
Obsessive Compulsive Disorder	yes/no	
Schizophrenia	yes/no	
Suicide Attempts	yes/no	
Other diagnosed mental health condition?	yes/no : which was---	

**Marital Status:**

- Never Married
- Domestic Partner
- Married
- Separated
- Divorced -- For how long?
- Widowed: Please provide your partners name and year deceased:

If married, how long have you been married for and what is your partners name:

\_\_\_\_\_

On a scale of 1-10 (best), how would you rate your relationship? \_\_\_\_\_

Are you currently in a romantic relationship?

- Yes -- How long? \_\_\_\_\_
- No

On a scale of 1-10 (best), how would you rate your relationship? \_\_\_\_\_

Please list any children, their names, and ages:

Name	Age	Relationship	Name of other parent	If deceased, age and cause of death
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## Physical Health

Please list any medications, herbs, or supplements. Be sure to include the condition, as some medications are prescribed for off-label use. Continue on the back if needed, or provide a separate list. If you have a complicated medical profile, please supply supporting documentation to be able to facilitate a comprehensive understanding of your health.

Medication/Supplement	Dosage	Condition	Date Began/Stopped
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Prescribing provider and contact information:

Name: \_\_\_\_\_

Specialty: \_\_\_\_\_

Facility: \_\_\_\_\_

Phone, email, or Fax: \_\_\_\_\_

How would you rate your current physical health?

- Poor
- Unsatisfactory
- Satisfactory
- Good
- Very Good

Please list any specific health problems you are currently experiencing:

How would you rate your current sleeping habits?

- Poor
- Unsatisfactory
- Satisfactory
- Good
- Very Good

If you are having problems, in which phase of sleep are you experiencing issues?

- Falling asleep
- Staying asleep
- Awakening early
- Sleep apnea

Please list any other specific sleep problems you are currently experiencing:

How many times per week do you generally exercise? \_\_\_\_\_ What types of exercise do you participate in:

Are you currently experiencing any chronic pain?

No

Yes

If yes, please describe:

Please describe current use of alcohol, cigarettes, and/or recreational drugs:

Please describe previous use of alcohol, cigarettes, and/or recreational drugs:

### **Additional Information**

What do you enjoy about your work (full-time homemaker included)? If retired, what did you enjoy about your work?

What do you find particularly stressful about your current or previous work?

What do you enjoy doing in your free time? What do you do to relax?

Do you consider yourself to be spiritual or religious? If yes, please describe your faith or belief:

What do you consider to be some of your strengths?

What do you consider to be some of your weakness?

# Limits of Confidentiality

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Psychotherapy is confidential, with the below stated exceptions.

**Duty to Warn:** Therapists are mandated by law to disclose pertinent information discussed in therapy if the client has an intent or plan to harm another person. We are required to inform the intended victim and notify legal authorities.

**Suicide/Self harm:** Depression is common emotion expressed in therapy, but if a client is feeling hopeless enough to imply or disclose a plan for suicide; steps need to be taken to ensure safety.

This would include notifying the legal authorities as well as make reasonable attempts to notify the family.

**Animal abuse:** I will report animal abuse, including cases of neglect and hoarding.

**Vulnerable Adults and Children:** Mental health professionals are required by law to report stated or suspected abuse of a child or vulnerable adult to the appropriate social service agencies and/or legal authorities.

**Prenatal Exposure to Controlled Substances:** in keeping with protecting vulnerable populations, Mental Health Providers are required to report admitted use of controlled substances during pregnancy that are potentially harmful to the fetus.

**Minors/Guardianship:** Parents or legal guardians have the right to access a minor client's health information. Age of adult for psychotherapy is \_\_\_\_\_.

**Insurance Providers:** Information requested includes description of impairments, dates and times of service, diagnosis, treatment plans, treatment progress, prognosis for improvement, case notes and summaries.

I have read and understand the above-stated limitations to confidentiality. I accept the subsequent ramifications should there be a need to act on one of the above-stated exceptions. Other than the noted exceptions, if there are reasons to disclose my protected confidential information I understand that I will be provided a Release of Information form.

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**CREDIT CARD PRE-AUTHORIZATION  
FOR USE BY E. NOACH SHAPIRO LCSW, LLC**

I authorize E. NOACH SHAPIRO LCSW, LLC to keep my signature on file and to charge my account for: Payment of my session in the amount established by my provider \_\_\_\_\_ (Amount)

For a No-Show or missed session without a 24 hour cancellation notice.

For a phone session.

For past due sessions.

I understand that my card will be charged only in the event that I fail to provide payment in full at the time of my session. I will be notified, verbally or by text, by my provider that the missed session or the past due session payment will be applied to my credit card.

I also understand that if I want to use my credit card for my session (s) that I will make a payment at the end of the session I will be attending using the physical credit card.

I agree that this form is valid for the length of therapy and authorization for the use of this card will be canceled at the termination of therapy.

Client's Name: \_\_\_\_\_

Card Holder's Name: \_\_\_\_\_

Card Holder's Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

Email: \_\_\_\_\_  Visa  Master Card  American Express

Card # \_\_\_\_\_

CSC# \_\_\_\_\_ (3-digit # on back of card)

Signature: \_\_\_\_\_ Exp. Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_