Intake Form

Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information.

Please fill out this form and bring it to your first session.

Name: _____
(Last) (First) (Middle Initial)
Name of parent/guardian

_____
(Last) (First) (Middle Initial)

Birth Date: _____/_____/_____ Age: _____ Gender: _____

Marital Status:

__ Never Married __ Domestic Partnership __ Married __ Separated

__ Divorced __ Widowed

Please list any children/age: _____

Address _____

_____

(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.

Referred by (if any): _____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

__ No

__ Yes, previous therapist/practitioner: _____

Are you currently taking any prescription medication?

__ Yes

__ No

Please list: _____

_____

Have you ever been prescribed psychiatric medication?

__ Yes

__ No

Please list and provide dates: _____

_____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

How would you rate your current physical health? (Please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:

_____

How would you rate your current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

_____

How many times per week do you generally exercise? _____

In what types of exercise do you participate _____

Please list any difficulties you experience with your appetite or eating patterns.

_____

Are you currently experiencing overwhelming sadness, grief, or depression?

__ No

__ Yes

If yes, for approximately how long? _____

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

__ No

__ Yes

If yes, when did you begin experiencing this? _____

Are you currently experiencing any chronic pain?

__ No

__ Yes

If yes, please describe _____

Do you drink alcohol more than once a week? __ No __ Yes

Are you currently in a romantic relationship? __ No __ Yes

If yes, for how long? _____

On a scale of 1-10, how would you rate your relationship? _____

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

FAMILY MENTAL HEALTH HISTORY:

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.).

	Please circle	List Family Member
Alcohol/Substance Abuse	yes/no	
Anxiety	yes/no	
Depression	yes/no	
Domestic Violence	yes/no	
Eating Disorders	yes/no	
Obesity	yes/no	
Obsessive Compulsive Behavior	yes/no	
Schizophrenia	yes/no	
Suicide Attempts	yes/no	

ADDITIONAL INFORMATION:

Are you currently employed? __ No __ Yes

If yes, what is your current employment situation:

_____

Do you enjoy your work? Is there anything stressful about our current work?

_____

_____

Do you consider yourself to be spiritual or religious? __ No __ Yes

If yes, describe your faith or belief:

_____

What do you consider to be some of your strengths?

_____

_____

What do you consider to be some of your weaknesses?

_____

_____

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

_____

_____