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 (if under 18 years):

_____
(Last) (First) (Middle Initial)

Birth Date: _____/_____/_____Age: _____ Gender: ❑ Male ❑ Female

Marital Status:
❑ Never Married ❑ Domestic Partnership ❑ Married ❑ Separated
❑ Divorced ❑ Widowed

Please list any children/ age: _____

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.

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: _____

Check any of the following that may apply to you (and partner if applicable. S=self/ P=partner):

Headaches	Inferiority Feelings	Shy with people
Dizziness	Feel Tense	Can't make friends
Fainting spells	Feel panicky	Afraid of people
No appetite	Fears and phobias	Home conditions bad
Over-eating	Obsessions	Unable to have a good time
Stomach trouble	Depressed	Always worried about something
Bowel disturbances	Suicidal ideas	Don't like weekends/vacations
Always tired	Take tranquilizers	Can't make decisions
Always sleepy	Alcoholism	Over-ambitious
Unable to relax	Dangerous drugs	Financial problems
Insomnia	Allergy	Gambling
Recurrent dreams	Asthma	Job problems
Nightmares	Sexuality issues	Can't keep a job
Hallucinations	Sexual problems	Trauma history
Arrest	Sexual abuse/ Rape	Incarceration
Victim of a crime	Criminal behavior	Child abuse/ Neglect

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. 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:

_____

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

Poor Unsatisfactory Satisfactory Good Very Good

Please list any specific sleep problems you are currently experiencing:

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3. How many times per week do you generally exercise? _____

What types of exercise do you participate in: _____

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

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5. Are you currently experiencing overwhelming sadness, grief, or depression?
❑No
❑Yes

If yes, for approximately how long? _____

6. Are you currently experiencing anxiety, panic attacks, or have any phobias?
❑No
❑Yes

If yes, when did you begin experiencing this? _____

7. Are you currently experiencing any chronic pain?
❑No
❑Yes

If yes, please describe: _____

8. Do you drink alcohol more than once a week? ❑Yes ❑No

9 How often do you engage in recreational drug use? ❑Daily ❑Weekly ❑Monthly ❑Infrequently ❑Never

10. Are you currently in a romantic relationship? ❑Yes ❑No

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

11. Level of education: ____ yrs completed. GED HS Jr College College Post Graduate/ Masters/ PhD/ Other

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

_____

_____

_____

ADDITIONAL INFORMATION:

1. Are you currently employed? ❑Yes ❑No

If yes, what is your current employment situation?

_____

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

_____

_____

2. Do you consider yourself to be spiritual or religious? ❑Yes ❑No

If yes, describe your faith or belief:

_____

3. What do you consider to be some of your strengths?

_____

_____

_____

4. What do you consider to be some of your weaknesses?

_____

_____

_____

_____

_____

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

_____

_____

_____

_____

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	