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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)

Phone Number:
_____
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

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:

_____

3. How many times per week do you generally exercise? _____
What types of exercise to you participate in?

_____

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

_____

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. Do you have a history of suicidal ideation or suicide attempts?
□ No □ Yes
If yes, please discuss:
_____

8. Are you currently experiencing any chronic pain?
□ No □ Yes
If yes, please describe:
_____

9. Do you drink alcohol more than once a week?
□ Daily □ Weekly □ Monthly

How often do you engage recreational drug use?
□ Daily □ Weekly □ Monthly

10. Are you currently in a romantic relationship?
□ No
□ Yes
If yes, for how long? _____

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

12. 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 (father, grandmother, uncle, etc.).

Alcohol/Substance Abuse
Anxiety
Depression
Domestic Violence
Eating Disorders
Obesity
Obsessive Compulsive Behavior
Schizophrenia
Suicide Attempts

ADDITIONAL INFORMATION: 1. Are you currently employed? □ No □ Yes
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? □ No □ Yes
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?