INTAKE FORM

Please take time to fill out as much information as possible, in order for me to better help you.

Presenting Problem – Please describe the problem or situation that brings you here:

____

____

____

I – GENERAL INFORMATION

Name: ____

DOB: ______________________ Age: ______________ Gender: ______________

Address: ____

____

Contact: (Please mark with * the best way to reach you):

H ______________________________ W ______________________________

Cell: ____________________________ Email: ____________________________

Insurance Plan Name: ______________________ ID #: ______________________

Name of Insured (if different): ____

DOB if Insured (if different): ____

Address of Insured (if different): ____

____

Referred by ____

II. GENERAL HEALTH AND MENTAL HEALTH INFORMATION

Have you been in therapy before? _____Yes _____No

If yes, when, for how long and what was the issue you worked on?

____

____

Have you ever been prescribed psychiatric medication? _____Yes _____No

If yes, please list names, reasons and provide dates: ____

____

____

Are you currently taking other prescription medication not listed above? _____Yes _____No

Please list: ____

____

____

How do 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 sleeping habits? (Please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:

____

____

How many times a week do you generally exercise? ____

What type of exercise? ____

Please list any difficulties you may be experiencing with your appetite or eating patterns.

____

____

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/fears? _____Yes _____No

If yes, when did you begin experiencing this? ______________________________

____

Are you currently experiencing chronic pain? _____Yes _____No

If yes, please describe ______________________________

____

Do you drink alcohol? ____Daily ____Weekly ____Monthly _____Rarely _____ Never

Please describe about how many glasses and what type of drinks.

____

____

Do you take recreational drugs? ____Daily ____Weekly ____Monthly _____ Rarely _____ Never

Please describe about how much and what types.

____

____

What significant life changes or stressful events have you experienced lately (or in the past, if relevant)?

____

____

RELATIONSHIPS (Please circle)

Single Domestic Partnership Married Separated Divorced Widowed

If you are currently in a romantic relationship, for how long? ______________________________

On a scale of 1 to 10, how would you rate your relationship? ______________________________

Please list the people who are important in your life:

NAME	AGE	RELATIONSHIP (parent, sibling, etc)	DESCRIBE RELATIONSHIP (close, distant, conflictive, abusive, etc.)

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, brother, etc.)

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

Are you currently employed/studying? _____Yes _____No

If yes, what is your current employment/study situation? ____

Do you enjoy your work/study? Is there anything stressful about your work/study?

____

____

Do you consider yourself to be spiritual or religious? _____Yes _____No

If you don't mind, 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 weaknesses?

____

____

____

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

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