Julian & associates

PSYCHOTHERAPY SERVICES

Intake Form

Please provide the following information and answer the questions below. Please fill out this form and bring it to your first session. Please note: Information you provide here is protected as confidential information.

GENERAL INFORMATION

Client's name: _____
(Last) (First) (Middle Initial)

Name of parent or legal guardian (if under 18 years of age)

_____
(Last) (First) (Middle initial)

Client's Date of Birth: _____ Age: _____ Gender: (circle) Male Female

Marital Status: (circle)

Never Married Domestic Partnership Married

Separated Divorced Widowed

Please list any children/age: _____

Please list any other family members living in the same household: _____

Please list other unrelated people living in the same household: _____

Client's 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 Address: _____ May we email you? ____Yes ____No

(Please note: E-mail correspondence is not considered to be a confidential medium of communication)

Emergency Contact Name: _____ Relationship to Contact: _____

Home Phone: _____ Cell Phone: _____

Referred by (if any) _____

INSURANCE INFORMATION (if applicable)

Please bring your insurance card(s) or a copy to your first appointment.

Primary Insurance Company: _____ Policy ID #_____

Group No.: _____Plan Name: _____ Insured's Employer/School _____

Policy Holder's Name: _____Policy Holder's Date of Birth: / /

Policy Holder's Address: _____ City: _____ State: ____ Zip: _____

Secondary Insurance Company: _____ Policy ID #_____

Group No.: _____Plan Name: _____ Insured's Employer/School _____

Policy Holder's Name: _____Policy Holder's Date of Birth: / /

Policy Holder's Address: _____ City: _____ State: ____ Zip: _____

TREATMENTS & MEDICATIONS

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

___No ___Yes, previous therapist/practitioner: _____

Are you/your child currently taking any prescription medications? ____Yes ____No

If yes, please list:

Medication Name: _____ How Long? _____

Medication Name: _____ How Long? _____

Have you/your child ever been prescribed psychiatric medication? ____Yes ____No

If yes, please list and provide dates:

Medication Name: _____ Dates: _____ to _____

Medication Name: _____ Dates: _____ to _____

HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your/your child's current physical health? (circle)

   Poor Unsatisfactory Satisfactory Good Very Good

   Please list any specific health problems you/your child are currently experiencing:

   _____

2. How would you rate your/your child's current sleeping habits? (circle)

Poor Unsatisfactory Satisfactory Good Very Good

Please list any specific sleep problems you/your child are currently experiencing:

_____

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

   What types of exercise do you/your child participate in?

   _____

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

   _____

5. Are you/your child currently experiencing overwhelming sadness, grief or depression? ____No ___Yes

   If yes, approximately how long? _____

6. Are you/your child currently experiencing anxiety, panic attacks or have any phobias? ____No ____Yes

   If yes, when did you/your child begin experiencing this? _____

7. Are you/your child currently experiencing any chronic pain? ____ No _____Yes

   If yes, please describe: _____

8. Have you/your child ever been a victim of physical abuse? ____No ____Yes
9. Have you/your child ever been a victim of sexual abuse? ____No ____Yes
10. Have you/your child ever experienced significant trauma? ____No ____Yes

ADDITIONAL INFORMATION

1. Are you/your child currently employed? ____No ____Yes

   If yes, what is your/your child current employment situation?

   Do you/your child enjoy the employment? ___No ____Yes

   Is there anything stressful about your/your child's current work?

2. Do you/your child consider yourself to be spiritual or religious? ____No ____Yes

   If yes, describe your/your child's faith or belief:

3. What do you consider to be some of your/your child's strengths?

4. What do you consider to be some of your/your child's weaknesses?

5. What would you like to accomplish during your/your child's time in therapy?

6. Do you/your child drink alcohol? ____No ____Yes
   If so, is it more than once a week? ____No ____Yes

7. How often do you/your child engage in recreational drug use? (circle)
   Daily Weekly Monthly Infrequently Never

8. Are you/your child currently in a romantic relationship? ____No ____Yes
   On a scale of 1-10, how would you rate your/your child's relationship? _____

9. What significant life changes or stressful events have you/your child experienced recently?

10. Did you/your child achieve developmental tasks on target? ____No ____Yes
    If no, please describe: _____

FAMILY MENTAL HEALTH HISTORY

In this section, 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 (ex. Father, grandmother, uncle, etc.)

			Family Member
Alcohol/Substance Abuse	____No	____Yes	_____
Anxiety	____No	____Yes	_____
Depression	____No	____Yes	_____
Domestic Violence	____No	____Yes	_____
Eating Disorders	____No	____Yes	_____
Obesity	____No	____Yes	_____
Obsessive Compulsive Behavior	____No	____Yes	_____
Schizophrenia	____No	____Yes	_____
Suicide Attempts	____No	____Yes	_____