NURTURING SOLUTIONS
A FAMILY THERAPY & CONSULTATION PRACTICE

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 □ Binary

Marital Status:

□ Never Married □ Domestic Partnership □ Married □ Separated □ Divorced □ Widowed

Please list all household members beginning with children:

Name	Age	Relation

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 send you email notifications? □Yes □No

Please note: Email correspondence is not considered to be a confidential medium of communication.

Emergency Contact:

Name: ____

Phone Number: (____) ________________

Referred by (if any): ______________________________________

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

□ Yes, previous therapist/practitioner: ____________________________ □ No

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 forms 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? □ Yes □ No

If yes, for approximately how long? ____________________

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

If yes, when did you begin experiencing this? ______________________

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

If yes, please describe? ____

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

9. How often do you engage recreational drug use?

□ Daily □ Weekly □ Infrequently □ Monthly □ 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 satisfaction? ________

11. 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.).

	YES	NO	Family Member
Alcohol/Substance Abuse			
Anxiety			
Depression			
Domestic Violence			
Eating Disorders			
Obesity			
Obsessive Compulsive Behavior			
Schizophrenia			
Suicide Attempts			
Completed Suicides			

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 your most challenging personality traits?

____

____

____

____

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

____

____