INTAKE FORM

Please fill out this form and bring it to your first session. Please note: information you provide here is protected as confidential information.

Today's Date: _____

Client Name: _____
(Last) (First) (Middle Initial)

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

email:_____ May we email you? ☐ yes ☐ no
*Please note: email correspondence is not considered to be a confidential medium of communication.

Birth Date: _____/_____/_____ Age: _____ Gender: _____

Marital Status: (Please circle)

Never Married Domestic Partnership Married
Separated Divorced Widowed

Please list any children/age: _____

Name of parent/guardian (if under 18 years of age):

_____
(Last) (First) (Middle Initial)

Referred by (if applicable) _____

Have you previously received any type of mental health services (Psychotherapy, Psychiatric Services, Counseling, etc.) and by whom?

_____

Are you currently taking any prescription medication? ☐ yes ☐ no

If yes, please list: _____

_____

Have you ever been prescribed psychiatric medication? ☐ yes ☐ no

If yes, please list: _____

_____

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 do 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 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 in recreational drug use? (please circle)

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. 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.)

	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	

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?

_____

_____

_____