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 or email it to me.

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)

Home Phone: _____ May we leave a message? □Yes □No

Cell: _____ May we leave a message? □Yes □No

Work Phone: _____ 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):

_____

Emergency Contact:
Name: _____

Relationship to you: _____

Phone number:_____

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.

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5. Are you currently experiencing overwhelming sadness, grief or depression?
□ No
□ Yes
If yes, for approximately how long? _____

6. Have you ever experienced periods of increased agitation, talkativeness, jumpiness, an exaggerated sense of confidence or invincibility, or risky or impulsive behavior?
□ No
□ Yes
If yes, please describe _____
_____

_____

How long do these periods last?_____

7. Are you currently experiencing anxiety, panic attacks or have any phobias?
□ No
□ Yes
If yes, when did you begin experiencing this? _____

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

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

10. How often do you engage in recreational drug use? □ Daily □ Weekly □ Monthly
□ Infrequently □ Never

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

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

12. What significant life changes or stressful events have you experienced recently?

_____

13. Have you ever experienced suicidal thoughts, ideations, or actions?
□ No
□ Yes

If yes, please describe the periods in your life when you have felt suicidal and when the most recent time was. _____
_____
_____

14. Have you ever been hospitalized for any medical or psychiatric reasons?
□ No
□ Yes
If yes, please describe. _____
_____

15. Have you ever experienced any type of trauma and/or physical or sexual abuse as a child, adolescent or adult?
□ No
□ Yes

CURRENT HABITS:
Please describe your current habits in each of the following areas:

Smoking:
Gambling:
Drinking:
Drug use:
Caffeine intake:
Exercise:
Meditation:
Eating:
Sleeping:
Time in Nature:
Fun and relaxation:
Artistic expression:

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 and List Family Member

Alcohol/Substance Abuse: yes/no
Anxiety: yes/no
Depression: yes/no
Bipolar Mood swings: 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? □ No □ Yes
If yes, name and address of your employer:

_____

_____

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 learning edges/limitations?

_____

_____

_____

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

_____

_____

_____

6. How would you describe your support system?

7. How would you know that your time in therapy has been successful?

_____
_____
_____
_____
_____

8. Is there anything else you would like me to know?