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.
Today's Date: _____

Name:

_____
(First) (Middle Initial) (Last)

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 Code) _____

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

Cell/Other 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):

_____

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:

_____

5. Are you currently experiencing overwhelming sadness, grief, or depression?
□ No □ Yes

If yes, for approximately how long? _____

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

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

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

9. How often do you engage recreational drug use?
□ Daily □ Weekly □ Monthly □ Never

10. 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? _____

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 circle and indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

Alcohol/Substance _____
Abuse Anxiety _____
Depression _____
Domestic Violence_____
Eating Disorders_____
Obesity Obsessive _____
Compulsive Behavior _____
Schizophrenia _____
Suicide Attempts_____

ADDITIONAL INFORMATION: 1. Are you currently employed? □ No □ Yes
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? □ No □ Yes If yes, briefly 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 in your therapy?

_____

_____

_____