.....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 Marital Status:
! Never Married ! Domestic Partnership ! Married ! Separated ! Divorced ! Widowed
Please list any children/age: _____
Address: _____ (Street and Number)
_____
(City)
(State) (Zip) May we leave a message? !Yes !No
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): _____
Home Phone: ( ) Cell/Other Phone: ( )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? _____
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
9. How often do you engage recreational drug use? ! Daily ! Weekly ! Monthly ! Infrequently ! 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 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

Please Circle List Family Member yes/no

Obesity Obsessive Compulsive Behavior Schizophrenia Suicide Attempts

yes/no yes/no yes/no yes/no yes/no yes/no yes/no

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, 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 weakness?

_____

_____

_____

_____

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

_____

_____

_____

_____