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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: _____

Address: _____
(Street and Number)

_____
(City) (State) (Zip)

Cell: _____May I leave a message? □ Yes □ No

May I text you? □ Yes □ No

E-mail: _____ May I email you? □ Yes □ No
*Please note: Email, text, and voicemail correspondence is not considered to be a confidential medium of communication.

Marital Status:
□ Never Married □ Domestic Partnership □ Married □ Separated

□ Divorced □ Widowed

Name of Partner/Spouse: _____Years together: _____

Number of Marriages: _____ Number of Divorces: _____

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? _____

Please list any children/age:

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

Other: _____

What significant life changes or stressful events have you experienced recently:

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?
□ No
□ Yes, previous therapist/practitioner: _____

What was your experience? _____

What medications or supplements are you currently on?

Please list: _____

_____

Have you ever been prescribed psychiatric medication?
□ Yes
□ No

Please list and provide dates: _____

_____

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	

Mother's name: _____

Age: _____ Deceased age: _____ Cause of death: _____ Supportive? _____

Father's name: _____

Age: _____ Deceased age: _____ Cause of death: _____ Supportive? _____

Sibling's name: _____

Age: _____ Deceased age: _____ Cause of death: _____ Supportive? _____

Sibling's name: _____

Age: _____ Deceased age: _____ Cause of death: _____ Supportive? _____

Sibling's name: _____

Age: _____ Deceased age: _____ Cause of death: _____ Supportive? _____

Personal History

I was sexually abused as a child _____ by whom: _____

I was physically abused as a child_____ by whom: _____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health? (Please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please check the right answers:

___ Headaches
___ Fatigue
___ Dizziness
___ Hives, rashes, skin disorders
___ Rapid heartbeats
___ Joints/muscles pain
___ Allergies to _____

Please list any specific health issues that you are being treated for or you are currently experiencing:

_____

_____

2. How would you rate your current sleeping habits? (Please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please check the right answers:

___ Can't get to sleep
___ Easy to go to sleep but wake up several times during the night
___ Sleep more than 8-10 hours a day

Please list any specific sleep problems you are currently experiencing:

_____

3. How many times per week do you generally exercise? _____

Types of exercise to you participate in _____

_____

4. Please list any difficulties you experience with your appetite or eating patterns:

Please check the right answers:

___ Acid Reflex
___ Ulcers
___ Irritable Bowel Syndrome
___ Nausea and/or Vomiting
___ Diarrhea

___ Constipation
___ Bloated
___ Binge eating
___ Restricted eating
___ Try to eat Organic
___ Vegetarian
___ Vegan
___ Other_____

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

If yes, for approximately how long? _____

Please check the right answers:

____ I have attempted suicide ____ times
____ I have never attempted suicide
____ I think about suicide often
____ I have a plan for suicide, it is: _____
____ I have been hospitalized for a psychiatric condition _____ times

Name of hospital/s: _____

_____

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

If yes, when did you begin experiencing this? _____

Please check the right answers:

____ Poor memory
____ Confusion
____ Poor concentration
____ Difficulty making decisions
____ Mood swings
____ Anger, irritability
____ Sense of despair

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

What do you drink? _____

9 Drug History

	Ever Used?	Ever a Problem?	Age of 1st Use	When last used?
Alcohol	Yes No	Yes No		
Sleeping pills	Yes No	Yes No		
Benzodiazepines (Ativan, Xanax, Klonopin, Valium, etc..)	Yes No	Yes No		
Caffeine	Yes No	Yes No		
Cocaine	Yes No	Yes No		
Ecstasy (MDMA)	Yes No	Yes No		
Glue	Yes No	Yes No		
Heroin	Yes No	Yes No		
Other inhalants (Paint, whiteout)	Yes No	Yes No		
LSD	Yes No	Yes No		
Marijuana or hashish	Yes No	Yes No		
Methadone	Yes No	Yes No		
Methamphetamine	Yes No	Yes No		
Mescaline	Yes No	Yes No		
Mushrooms	Yes No	Yes No		
Nicotine	Yes No	Yes No		
Opiates (pain pills)	Yes No	Yes No		
Opium	Yes No	Yes No		
PCP	Yes No	Yes No		
Peyote	Yes No	Yes No		
Steroids	Yes No	Yes No		
Steroid creams for skin	Yes No	Yes No		

Please check the right answers:

____ I have gone to _____rehabs
____ I need rehab
____ I am sober and have how much sobriety: _____
____ I go to a 12 Step Program named: _____
____ I have a sponsor
____ I go to _____ meetings a week

Names of Rehabs and year attended (list most recent) :

Month: _____Year: _____ Name:_____

Month: _____Year: _____ Name:_____

Month: _____Year: _____ Name:_____

Month: _____Year: _____ Name:_____

ADDITIONAL INFORMATION:

Are you currently employed? □ No □ Yes

What is your job title and name of employer?

_____

Do you enjoy your work? Is there anything stressful about your current work?

_____

_____

Do you consider yourself to be spiritual or religious? □ No □ Yes

If yes, describe your faith or belief:

_____

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

_____

_____

_____

_____

Referred by (if any): _____

Signature: _____ Date: _____

Print Name: _____