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INTAKE FORM

Please fill out this form and bring it to your first session. Please answer all questions and note that the information you provide here is protected as confidential information.

Name: ____
(First) (Middle) (Last)

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

____
(First) (Middle) (Last)

Birth Date: _________ /_________ /_________ Age: ___________

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

Occupation: ____
Please list any children/age: ____________________________________
Address: (Street, Apt. ____
____
(City) (State) (Zip)

Home Phone: ( ) - Cell/Other Phone: ( ) -
May I leave a message? □ Yes □ No May I leave a message? □ Yes □ No

E-mail: ______________________________ May I email you? □ Yes □ No (*Please note: Email correspondence is not considered to be a confidential medium of communication.)

Emergency Contact Information:
Name: ______________________________ Relationship:________________
Cell phone/other: ______________________

Referred by (if any): ____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)? □ No □ Yes
List previous therapist/practitioner and year(s) if possible:

1. ____
2. ____
3. ____
4. ____

Are you currently taking any prescription medication(s)? **□ Yes □ No**
Please list all:
1.____
2.____
3.____
4.____
5.____

Have you ever been prescribed psychiatric medication? □ Yes □ No
Please list PAST medications and provide dates/response:
1.____
2.____
3.____
4.____
5.____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health? (please circle)
Poor Unsatisfactory Satisfactory Good Very Good Excellent
Please list any specific health problems you are currently experiencing:
a.____
b.____
c.____
d. ____

Do you have an internist? Yes ____ No ____ Date of last check-up ________________

2. Somatic Complaints (Circle): Menstrual, headache, migraine, fatigue, dizziness, GI, excretory, sexual) Other ____
Describe:
____
____
____
____

3. Are you currently experiencing any chronic pain? **□ No □ Yes**
If yes, please describe: ____

4. How would you rate your current sleeping habits? (please circle)
Poor Unsatisfactory Satisfactory Good Very Good Excellent
Please list any specific sleep problems you are currently experiencing:
____
____
____

5. How many times per week are you physically active? ______________________________
What types of physical activities do you participate in? ______________________________
____
____
____

6. Please list any difficulties you HAVE EXPERIENCED OR CURRENTLY EXPERIENCE with your appetite or eating patterns, and whey they occurred:

Current**:**____
____
____
____

History:____
____
____
____

Do you eat three meals a day? **□ No □ Yes**

Describe eating patterns:
____
____
____
____

7. Are you currently experiencing overwhelming sadness or grief? □ No □ Yes

If yes, for approximately how long? ____

8. Are you currently experiencing anxiety, panic attacks, or phobias? □ No □ Yes

If yes, when did you begin experiencing this? ___________________________________

9. Do you/did you drink alcohol? Y ______ N ______ Current? Y _____ N ______

If so how often? Current/Amount □ Daily _____ □ Weekly _____ □ Monthly _______
Past/Amount □ Daily _____ □ Weekly _____ □ Monthly _______

10. Do you /did you ever engage recreational drug use? Y _____ N _____
Current? Y ____ N ____

If so how often? Current/Amount: □ Daily _____ □ Weekly _____ □ Monthly _______
Past/Amount: □ Daily _____ □ Weekly _____ □ Monthly _______

Type of substance(s) used:____
____
____
____

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 (parent, sibling, grandparent, aunt, uncle, etc.)

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 (parent, sibling, grandparent, aunt, uncle, etc.)

Alcohol/Substance Abuse □ No □ Yes ____

Child abuse (sexual, physical, emotional abuse) □ No □ Yes ______________________

Terrorism, natural disaster, war, or immigration trauma □ No □ Yes ________________

Psychiatric Hospitalization □ No □ Yes ____

Anxiety □ No □ Yes____

Depression □ No □ Yes____

Bipolar Disorder □ No □ Yes ____

Domestic Violence □ No □ Yes ____

Eating Disorders □ No □ Yes____

Personality Disorder □ No □ Yes ____

Obesity □ No □ Yes ____

Obsessive Compulsive Behavior □ No □ Yes ____________________________________

Schizophrenia/Psychosis □ No □ Yes ____

Suicide Attempts□ No □ Yes ____

Completed Suicide□ No □ Yes ____

Family Composition During Childhood:

____

____

____

____

____

____

Big Life Events (Divorce, death, move, etc.):

1. ____
2. ____
3. ____
4. ____

Please describe what has brought you to therapy at this time:

____

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What are your goals for therapy?

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