INTAKE FORM

Please provide the following information and answer the questions below.
Note: information you provide here is protected as confidential information.

Please fill out this form and bring it to your first session. Date ____ /____ / ____

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

Name of parent/guardian (if under 18 years): ______________________________
(Last) (First) (Middle Initial)

Birth Date: ______ / ______/ ______ Age: ______ Gender: ______

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/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: ______________________________

INTAKE FORM

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 do you participate? ____

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

____

INTAKE FORM

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

If yes, for approximately how long? ______________________________

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

If yes, when did you begin experiencing this? ______________________________

7. Are you currently experiencing any chronic pain?
☐ Yes ☐ No

If yes, please describe ______________________________

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

9.How often do you engage recreational drug use? *(please circle)*

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: ______________________

____

12. Are you currently employed? ☐ Yes ☐ No

If yes, what is your current employment situation: ______________________________

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

____

CONTINUED ON NEXT PAGE

INTAKE FORM

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	

ADDITIONAL INFORMATION:

2. Do you consider yourself to be spiritual or religious? ☐ Yes ☐ No

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? ______________________________

____