INTAKE FORM

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

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

Name of parent/guardian (if under 18) _____
(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)

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.)? □ Yes □ No

If yes, previous 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?

□ 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?

□ 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? _____

In which types of exercise do you participate? _____

4. Please list difficulties experienced with your appetite or eating patterns:

_____

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

If yes, for approximately how long? _____

6. Do you currently experience 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?

□ Daily □ Weekly □ Monthly □ Infrequently □ Never

10. Are you currently in a romantic relationship? □ Yes □ No

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.).

			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:

1. 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?

_____

_____

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 weaknesses?

_____

_____

_____

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

_____

_____

(If completing this form on a computer or tablet, please save, then print and bring with you to your appointment. Thank you.)