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:____ SS#: __________________
(Last) (First) (Middle Initial)

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

____
(Last) (First) (Middle Initial)

Birth Date:_______/_______/_______ Age:_______ Gender: M F

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

Please list any children/age:____

Address:____
(Street and Number)

____
(City) (State) (Zip)

Insurance information: ____

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: E-mail correspondence is not considered to be a confidential medium of communication.

You have my permission to contact the person below in an emergency:

_______________________________________ _______________________________
Name Phone number

Referred by (if any): ____

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?
____ Poor ____ Unsatisfactory ____ Satisfactory ____ Good ____ Very Good

Please list any specific health problems you are currently experiencing:

____

2. How would you rate your currently sleeping patterns?
____ Poor ____ Unsatisfactory ____ Satisfactory ____ Good ____ Very Good

Please list any specific health problems you are currently experiencing:

____

3. How many times per week do you exercise? ____________

What types of exercise do you participate in? ____

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

____

5. During the past month, how much of the time were you a happy person?

All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	None of the time
1	2	3	4	5	6

6. How much of the time, during the past month, have you felt calm and peaceful?

All of the time Most of the time A good bit of the time Some of the time A little of the time None of the time
1 2 3 4 5
6

7. How much of the time, during the past month, have you been a very nervous person?

All of the time Most of the time A good bit of the time Some of the time A little of the time None of the time
1 2 3 4 5
6

8. How much of the time, during the past month, have you felt downhearted and blue?

All of the time Most of the time A good bit of the time Some of the time A little of the time None of the time
1 2 3 4 5
6

9. How much of the time, during the past month, did you feel so down in the dumps that nothing could cheer you up?

All of the time Most of the time A good bit of the time Some of the time A little of the time None of the time
1 2 3 4 5
6

10. Are you currently experiencing overwhelming sadness, grief, or depression? ____ Yes ____ No

If yes, for approximately how long?____

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

If yes, when did you begin experiencing this? ____

12. Are you currently experiencing any chronic pain? ____ Yes____ No

If yes, please describe: ____

13. Do you drink alcohol more than once a week? ____ Yes ____ No

14. How often do you engage in recreational drug use?
____ Daily ____ Weekly ____ Monthly ____ Infrequently ____ Never

15. 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? ___________

16. Have you experienced any of the following in the last 12 months?

____ Death of family member or friend	____ New responsibilities and care for elder parents
____ Major legal troubles	____ DWI/DUI
____ Accused of crime/victim of crime	____ Recent birth of a child
____ Personal injury, illness or accident	____ Marriage
____ Problem with friend or family member	____ Family injury, illness, or accident
____ Abortion	____ Miscarriage
____ Sexual harassment	____ Sexual abuse, rape
____ Major change in financial status	____ Major geographic relocation
____ Major change in employment status	____ Serious job-related problems
____ Serious school-related problem	____ Change in close personal relationship (divorce, separation, break-up)

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:

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?

____

____

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