Today's Date:_____

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)

Birth Date: _____/_____ /_____ Age: _____ Gender: □ Male □ Female

Marital Status:

□ Never Married o Domestic Partnership □ Married
□ Separated o Divorced □ Widowed

Relationship Status:

□ Currently in a Relationship □ Currently not in a Relationship

Please list any Children/Ages:_____

Address: _____

(Street and Number)

_____

(City) (State) (Zip)

Cell Phone: _____ May I leave a Voice Message? □ Yes □ No

May I send a Text Message? □ Yes □ No

E-mail:_____May I email you? o Yes o 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.)?

o No

o Yes, previous therapist/practitioner(s): _____

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 to you participate in? _____

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

_____

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

If yes, for approximately how long? _____

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

If yes, when did you begin experiencing this? _____

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

9. How often do you engage recreational drug use?
□ 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:

_____

_____

_____

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? o No □ Yes

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? □ No □ Yes

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 problem, challenging issue, or area of personal growth do you wish to work on? Please be as specific as possible.

_____

_____

_____

_____

6. When did this problem, challenging issue or area of personal growth first appear? Is this recent?

_____

_____

_____

7. How have you tried to address this issue? What attempts have you made to make this better?

8. What happens when you try to make improvements? Do things get better? Do they get worse?

9. What outcome are you looking for? What would “successful” therapy look like for you?

10. Any other thoughts you wish to add?

Thanks so very much for taking time to fill out this Intake Form! Your personal thoughts and input is so very valuable and important for us to achieve positive results!