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)

_____
(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.)

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(s)? □ Yes □ No

Please list all:

_____

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 Excellent

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 Excellent

Please list any specific sleep problems you are currently experiencing:

_____

_____

3. How many times per week are you physically active? _____

What types of activities do you participate in? _____

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

_____

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

If yes, for approximately how long? _____

6. Are you currently experiencing anxiety, panic attacks, or 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. How often do you drink alcohol? _____ times per week _____times per month

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

Alcohol/Substance Abuse □ No □ Yes _____

Anxiety □ No □ Yes_____

Depression □ No □ Yes_____

Domestic Violence □ No □ Yes _____

Eating Disorders □ No □ Yes_____

Obesity □ No □ Yes _____

Obsessive Compulsive Behavior □ No □ Yes _____

Schizophrenia □ No □ Yes _____

Suicide Attempts□ No □ Yes _____

Completed Suicide□ No □ Yes _____

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

_____

_____

_____

_____

_____

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