Intake Form

Please note: the information you provide here is protected as confidential information.

Name: _____
(Last) (First)

Birth Date: _____/_____/_____ Age: _____

Please list any Children/Age: _____

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

Address: _____
(Street)

_____
(City) (State) (Zip)

Cell Phone: (_____)_____

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

May I leave a voice mail message on your cell phone? ☐ Yes ☐ No
May I text you to confirm appointments? ☐ Yes ☐ No

Referred by (if any) _____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

- No
- Yes Name of previous therapist/practitioner: _____

Are you currently taking any prescription medication?

- Yes
- No

Please list medications along with dosages:

_____

_____

_____

_____

Have you experienced anything in your life that has badly hurt you or you view as traumatic? Some examples are: relational or emotional neglect, sexual abuse, physical abuse, witnessing extreme violence or death, an experience that caused you to fear for your life, etc.

General Health and Mental Health Information

1. How would you rate your current physical health? (please circle)

   Poor Unsatisfactory Satisfactory Good Very Good

1. How would you rate your current sleeping habits? (please circle)

   Poor Unsatisfactory Satisfactory Good Very Good

2. How many times per week do you exercise? _____

   In what types of exercise do you engage? _____

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

   _____

4. Are you currently experiencing overwhelming sadness, grief, or depression?

   ☐ No ☐ Yes

   If yes, for approximately how long? _____

5. Are you currently experiencing anxiety, panic attacks or have any phobias?

   ☐ No ☐ Yes

   If yes, when did you begin experiencing this? _____

6. Are you currently experiencing chronic pain? ☐ No ☐ yes

   If yes, please describe _____

7. How often to you drink alcohol?

   ☐ Daily ☐ Weekly ☐ Monthly ☐Infrequently ☐ Never

8. How often do you engage in recreational drug use?

   ☐ Daily ☐ Weekly ☐ Monthly ☐Infrequently ☐ Never

9. Are you currently in a romantic relationship? ☐No ☐Yes

If yes, for how long? _____

On a scale of 1-10 (with “1” being terrible and “10” being near perfect), how would you rate your relationship? _____

10. What significant life changes or stressful events have you experienced lately?

_____

_____

_____

_____

Family Mental Health History:

In the section below, identify any family history 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	_____
Obsessive Compulsive Behavior	Yes/No	_____
Schizophrenia	Yes/No	_____
Suicide Attempts	Yes/No	_____

Additional Information:

1. Are you currently employed? ☐ No ☐ Yes

   If yes, describe your current employment?

   _____

   _____

   Do you enjoy 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 would you like to accomplish in our time together in therapy?

_____

_____

_____

_____

_____

_____

Date: _____/_____/_____

Please print this form, fill it out and bring it with you to your first session. Thank you.