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)

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

_____
(Last) (First) (Middle Initial)

Birth Date: _____ /_____ /____ Age: _____Gender: _____ Last 4 digits of SS_____

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

Spouse/Partner's Name:_____

Please list any children/age: _____

_____

Home Address:_____
(Street and Number)

(City)_____ (State)_____ (Zip)_____

Home Phone_____ 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.)?

□ 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? (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 sadness, grief or depression? □ No □ Yes

If yes, for approximately how long? _____

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

If yes, when did you begin experiencing this? _____

7. Are you currently experiencing any chronic pain? □ No □ Yes

If yes, pleas 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, how long? _____On a scale of 1-10, how would you rate the relationship? _____

11.Are you experiencing difficulties with sexual acting out/pornography/cybersex?

□ No □ Yes If yes, please describe_____

12. What significant life changes or stressful events have you experienced recently:

_____

_____

_____

_____

13. Are you currently employed? □ No □ Yes By Whom:_____

Do you enjoy your work? Is there anything stressful about your current work?

_____

_____

14. Do you consider yourself to be spiritual or religious? □ No □ Yes
If yes, describe your faith or belief:

_____

_____

15. What do you consider to be some of your strengths?

_____

_____

16. What do you consider to be some of your weakness?

_____

_____

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

_____

_____

_____

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.).

Alcohol/Substance	yes/no	_____
Abuse 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	_____