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: □ Male □ Female

Marital Status:

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

Please list any children/age: ____

____

Address: ____
(Street and Number)

____
(City) (State) (Zip)

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: 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

If so, please list: ____

____

Have you ever been prescribed psychiatric medication?

□ Yes □ No

If yes, 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 in 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? □ 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 weakness?

____

____

____

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

____

____

____

Please indicate if you are currently or have in the past experienced any of the following::

Depression / Mood Symptoms

Problem	**Current**	**Past Year**	**> 1 year ago**	**Problem**	**Current**	**Past Year**	**> 1 year ago**
Shortness of breath	☐	☐	☐	Weight loss	☐	☐	☐
Chronic Sadness	☐	☐	☐	Weight Gain	☐	☐	☐
Irritability	☐	☐	☐	Hopelessness	☐	☐	☐
Crying Episodes	☐	☐	☐	Thoughts of Suicide	☐	☐	☐
Low Frustration Level	☐	☐	☐	Low energy / fatigue	☐	☐	☐
Overeating	☐	☐	☐	Nausea / vomiting	☐	☐	☐
Withdrawing from others	☐	☐	☐	Difficulty Concentrating	☐	☐	☐
Extreme highs & lows	☐	☐	☐	Loss of appetite	☐	☐	☐
Difficulty functioning at work	☐	☐	☐	Difficulty falling asleep	☐	☐	☐
Difficulty functioning socially	☐	☐	☐	Sleeping too much or too little	☐	☐	☐
Reduced interest / reduced pleasure	☐	☐	☐	Pounding heart / palpitation	☐	☐	☐
Feelings of worthlessness & guilt	☐	☐	☐	No Interest in daily activities	☐	☐	☐
Difficulty making decisions	☐	☐	☐	Recurring Thoughts of death and dying	☐	☐	☐

Anxiety

Avoid Public Places	☐	☐	☐	Chest Pain	☐	☐	☐
Trembling/Shaking	☐	☐	☐	Fearfulness	☐	☐	☐
Agitation	☐	☐	☐	Distracted	☐	☐	☐
Fear of Dying	☐	☐	☐	Panic Attacks	☐	☐	☐
Excessive Worry	☐	☐	☐	Restlessness	☐	☐	☐
Difficulty Concentrating	☐	☐	☐	Fear of Losing Control	☐	☐	☐
Fear of Leaving Home	☐	☐	☐	Avoid Social Situations	☐	☐	☐

Attention

Difficulty Waiting	☐	☐	☐	Difficulty Organizing	☐	☐	☐
Racing thoughts	☐	☐	☐	Impulsive	☐	☐	☐
Difficulty concentrating	☐	☐	☐	Forgetfulness	☐	☐	☐
Taking on too much at once	☐	☐	☐	Difficulty following Directions	☐	☐	☐
Don't finish what you start	☐	☐	☐	Constantly moving/pacing	☐	☐	☐
Difficulty starting a new task	☐	☐	☐				

Eating Problems							
Problem	**Current**	**Past Year**	**> 1 year ago**	**Problem**	**Current**	**Past Year**	**> 1 year ago**
Worry about being underweight	☐	☐	☐	Worry about being overweight	☐	☐	☐
Obsessed with weight	☐	☐	☐	Excessive Laxative use	☐	☐	☐
Self-induced vomiting	☐	☐	☐	Extreme exercising	☐	☐	☐
Obsessed with food	☐	☐	☐				
Trauma / Stress							
Flashbacks/reliving bad experiences	☐	☐	☐	Intrusive thoughts or bad memories	☐	☐	☐
Self-abuse/cutting	☐	☐	☐	Difficulty Concentrating	☐	☐	☐
Hyper-vigilance	☐	☐	☐	Feeling tense	☐	☐	☐
Easily startled/upset	☐	☐	☐	Nightmares	☐	☐	☐
Other Problem Areas							
Parent-child relationship issues	☐	☐	☐	High risk sexual behavior	☐	☐	☐
Financial concerns	☐	☐	☐	Grief/Loss	☐	☐	☐
Excessive gambling	☐	☐	☐				
Thinking Problems							
Feelings of being followed/ or stalked	☐	☐	☐	Fearful someone is plotting against you	☐	☐	☐
Fearful others are talking about you	☐	☐	☐	Hearing voices/ seeing things others do not	☐	☐	☐
Substance Abuse							
Excessive use of alcohol/drugs	☐	☐	☐	Use of substances to cope	☐	☐	☐
Failed at effort to reduce use of drugs	☐	☐	☐	Adult child of an alcoholic parent	☐	☐	☐
Others think I have a substance problem	☐	☐	☐	Cigarette use causing health problems	☐	☐	☐
Substance use causing problems with friends / family / work	☐	☐	☐	Health problems / accidents due to substance use	☐	☐	☐
Legal problems related to substance use	☐	☐	☐				