Intake Information

Please fill out this form and bring it to your first session.
Please note: the information you provide here is protected as confidential information.

Name: _____
(Last) (First) (Middle Initial)

Name of parent/guardian (if under 18 years):
_____
(Last) (First) (Middle Initial)

Address: _____
(Street and Number)
_____
(City) (State) (Zip)

Birth Date: _____ /_____ /_____ Age: _____ Gender: _____

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

Please list any children/age: _____

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.
We will keep your email address confidential.

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 dosages and how long you have taken them:
_____
_____

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 do 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 please identify if there is a family history of any of the following problems. If yes, please circle yes and indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.) Names are not necessary.

Please 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 in therapy?
_____
_____
_____