

Intake Form

DATE \_\_\_\_\_

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: \_\_\_\_\_

Name \_\_\_\_\_

Are you currently taking any prescription medication?

Yes

No

Please list:

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Have you ever been prescribed psychiatric medication?

Yes

No

Please list and provide dates:

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#### 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:

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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:

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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:

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

No

Yes

If yes, for approximately how long? \_\_\_\_\_

Name \_\_\_\_\_

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

11. Are you currently in a romantic relationship?  No  Yes

If yes, for how long? \_\_\_\_\_

11. On a scale of 1-10, how would you rate your relationship? \_\_\_\_\_

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

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#### 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 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

Name \_\_\_\_\_

**ADDITIONAL INFORMATION:**

Are you currently employed?  No  Yes

If yes, what is your current employment situation?

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

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What do you consider to be some of your strengths?

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

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