I N T A K E F O R M

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

If married/domestic partnership, name/age of significant other: _____

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.

Emergency Contact (name/phone): _____

Referred by (if any): _____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?
□ No
□ Yes, previous therapist/practitioner: _____

Have you previously received treatment in a psychiatric hospital, partial day program or residential treatment center?
□ No
□ Yes, name of facility and date(s) of treatment:_____

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 overwhelming sadness, grief or depression?
□ No
□ Yes

If yes, for approximately how long? _____

6. Do you have any thoughts now or recently or wishing you were dead?
□ No
□ Yes
If yes, please explain: _____

7. Have you ever attempted to commit suicide or seriously harm yourself?
□ No
□ Yes
If yes, please explain: _____

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

If yes, when did you begin experiencing this? _____

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

If yes, please describe _____

10. Do you drink alcohol more than once a week? □ No □ Yes

11. When you drink, how much do you consume? _____

12. How often do you engage recreational drug use? □ Daily □ Weekly □ Monthly
□ Infrequently □ Never

If yes, describe your use: _____

13. 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? _____

14. 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
ADHD	yes/no	
Alcohol/Substance Abuse	yes/no	
Aggression/Violence	yes/no	
Anxiety	yes/no	
Depression	yes/no	
Domestic Violence	yes/no	
Eating Disorders	yes/no	
Gambling Addiction	yes/no	
Mood Swings	yes/no	
Obesity	yes/no	
Obsessive Compulsive Behavior	yes/no	
Paranoia	yes/no	
Schizophrenia	yes/no	
Sexual Abuse	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. Are you experiencing any financial problems?
   - □ No
   - □ Yes, describe:_____

3. Do you have any previous military experience?

 No

 Yes, describe:_____

4. Are you experiencing any legal difficulties?

 No

 Yes, describe:_____

5. Do you consider yourself to be spiritual or religious? □ No □ Yes

If yes, describe your faith or belief:

_____

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

_____

_____

_____

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

_____

_____

_____

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

_____

_____

_____