# 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

☐ Yes

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. 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 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 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?

_____

_____

_____