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## 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:

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(Last) (First) (Middle Initial)

Name of parent/guardian (if under 18 years):

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(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:

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Address:

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(Street and Number)

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(City) (State) (Zip)

Phone Number:

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May we leave a message?  Yes  No

E-mail: 

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May we email you?  Yes  No

\*Please note: Email correspondence is not considered to be a confidential medium of communication.

Referred by (if any):

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

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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?

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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?

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6. Are you currently experiencing anxiety, panic attacks, or have any phobias?

No  Yes

If yes, when did you begin experiencing this?

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7. Do you have a history of suicidal ideation or suicide attempts?

No  Yes

If yes, please discuss:

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8. Are you currently experiencing any chronic pain?

No  Yes

If yes, please describe:

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9. Do you drink alcohol more than once a week?  Daily  Weekly  Monthly

How often do you engage recreational drug use?  Daily  Weekly  Monthly

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

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

11. On a scale of 1-10 (1 being unhealthy 10 being extremely), how would you rate your relationship? \_\_\_\_\_

12. 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 (father, grandmother, uncle, etc.).

Alcohol/Substance Abuse Anxiety

Depression

Domestic Violence

Eating Disorders

Obesity

Obsessive Compulsive Behavior Schizophrenia

Suicide Attempts

ADDITIONAL INFORMATION: 1. 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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2. Do you consider yourself to be spiritual or religious?  No  Yes

If yes, describe your faith or belief:

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

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4. What do you consider to be some of your weaknesses?

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

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