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.

Today's Date: _____

Name: _____

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

_____

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

Referred by (if any): _____

Insurance: _____

Group ID: _____ Policy Number: _____

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 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 How many? _____

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 _____

Are you currently experiencing any suicidal thoughts or ideation? yes/no

Any previous attempts or hospitalizations as a result of ideation or thoughts? 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 weaknesses?

_____

_____

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

_____

_____

DO NOT FILL OUT BELOW THIS LINE_____

Axis I: _____; _____; _____; _____ Axis II: _____ Axis III _____

Axis IV: _____ Axis V: _____; _____; _____; _____; _____

Dual Diagnosis: _____; _____; _____