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INTAKE FORM

Personal Information

Date _____

Last Name _____ First Name _____

Address _____

City _____ State _____ Zip _____

Email Address _____ Occupation _____

Home Phone _____ Work Phone _____

Cell Phone _____ Alternative Phone _____

Is it acceptable to contact you at home? Y/N Is it acceptable to contact you via cell phone or email? Y/N
If "no" to all three, what alternative method could you provide for me to contact you?

Gender (M/F) _____ DOB (mm/dd/yyyy) _____ Age _____

Cultural Heritage _____ Sexual Orientation _____ Religion _____
(optional) (optional) (optional)

Relationship Status (please check as many of the following options that apply to you)

- Single Committed Relationship Married Separated
 Divorced Domestic Partnership (living together, but not married) Widowed

If you are in a relationship are you happy and satisfied with it? Y/N

If no, what would you like to be different? _____

How long have you been together? _____

Current Living/Family Situation

Do you have children? Y/N

If yes, please list names and ages: _____

Do they live with you? Y/N If no, please note where they are currently living: _____

Are there any other people outside of those already mentioned (related or unrelated) that are living in your home? Y/N

If yes, please list who they are, how you know them and why you are currently living together:

Education/Employment Information

Are you currently in school? Y/N

If yes, what institution do you currently attend? _____

What degree are you pursuing? _____

What is the highest grade in school that you completed? _____

Are you currently employed? Y/N

If yes, where do you work and what is the nature of your job? _____

Are you happy and satisfied at work? Y/N

If no, what would you to be different? _____

What are some of your strengths, interests and talents? _____

General Assessment

How did you hear about my services? _____

Are you or anyone close to you in any immediate danger? _____

Please describe briefly the concerns bringing you here today.

Please describe briefly some goals you have for therapy and what you would most like to get out of our time together.

Medical and Psychiatric History *(please write more on the back page if necessary)*

Are you currently under medical care? Y/N

If yes, then please explain/describe. _____

Name of Personal Physician & Phone Number: _____

Are you currently being treated for any chronic pain? Y/N

If yes, then please explain/describe. _____

Are you currently taking prescribed or over the counter medications (Please include all vitamin or herbal supplements)? Y/N

If yes, then please explain/describe. _____

List any psychiatric/mental health medications you have taken or are taking.

How do you feel about taking prescription medication for mental health issues like depression or anxiety?

Definitely Fine Unsure Opposed Very Opposed

Have you ever been diagnosed with a mental health disorder? Y/N

If yes, please briefly describe the diagnosis and circumstances surrounding it.

Have you been or are you currently under the care of a psychiatrist, psychologist, or counselor? Y/N

If yes, please give the name, date, and location of the therapy and briefly explain the nature of the problem, which required attention. _____

If yes to the above question, please provide a few details about how you felt about therapy. Was it a good or bad experience for you?

Have you ever been hospitalized for physical or mental health issues? Y/N

If yes, please give the name, date, and location of the therapy and briefly explain the nature of the problem, which required attention.

Have you ever attempted suicide? Y/N

If yes, please describe the events leading up to and the circumstances surrounding the attempt.

Current Mental State

Please check any of the following struggles that pertain to you:

- Anxiety Depression Fears/Phobias Finances Anger Sexual Problems
 - Suicidal Thoughts Relationships Insomnia Drug/Alcohol Use Career Choices
 - Self-Control Unhappiness Religious Matters Work/Stress Health Problems
 - Grief/Loss Cutting/Self-Mutilation Thought Patterns Separation/Divorce
 - Death of someone close Loneliness Past or current trauma Infertility Abortion
 - Domestic Violence Adoption Issues Cultural/Sexual Identity Academic Issues
 - Eating Disorders Sexual Assault Childhood Abuse (physical, sexual or emotional)
 - Family Concerns Postpartum Depression Addictions Despair Unwanted Pregnancy
- Other _____

If you currently experience any of the following symptoms, please rate them using the key below:

Seldom =0

Often=1

Continuous =2

Consuming=3

- | | | |
|---|---|--|
| <input type="checkbox"/> Difficulty Concentrating | <input type="checkbox"/> Feeling out of control | <input type="checkbox"/> Injuring self |
| <input type="checkbox"/> Crying | <input type="checkbox"/> Feelings of guilt | <input type="checkbox"/> Feeling afraid |
| <input type="checkbox"/> Missing classes/work | <input type="checkbox"/> Memory loss/blackout | <input type="checkbox"/> Excessive spending |
| <input type="checkbox"/> Feeling helpless | <input type="checkbox"/> Difficulty sleeping | <input type="checkbox"/> Recurring dreams/
nightmares |
| <input type="checkbox"/> Feeling uptight | <input type="checkbox"/> Stealing | <input type="checkbox"/> Feelings of despair |
| <input type="checkbox"/> Worrying | <input type="checkbox"/> Uncontrollable Anger | <input type="checkbox"/> Loneliness |
| <input type="checkbox"/> Feeling hopeless | <input type="checkbox"/> Eating binges | <input type="checkbox"/> Cutting |
| <input type="checkbox"/> Lying to others | <input type="checkbox"/> Eating purges | <input type="checkbox"/> Excessive anxiety in social
situations |
| <input type="checkbox"/> Recent weight loss | <input type="checkbox"/> Heavy drinking | |
| <input type="checkbox"/> Recent weight gain | <input type="checkbox"/> Heavy substance abuse | |
| <input type="checkbox"/> Feelings of self-doubt | <input type="checkbox"/> Withdrawing socially | |
| <input type="checkbox"/> Sexual preoccupation | <input type="checkbox"/> Nervous around others | |

Do you exercise regularly? Y/N

If yes, what type of exercise do you typically engage in? _____

Do you drink alcohol on a regular basis? Y/N

If yes, how often do you drink alcohol? _____

When you drink, how much do you usually consume? _____

Do you engage in recreational or prescription drug use/abuse? Y/N

If yes, how often do you engage in recreational or prescription drug use/abuse? _____

What do you use and how much? _____

Has anyone you know ever thought you had a problem with alcohol or drugs? _____

Are your current eating habits satisfactory? Y/N

If no, how would you like to see them change or what would you like to be different??

How are your current sleep patterns? (please circle one of the options below)

Poor

Erratic

Satisfactory

Good

Excellent

What important life changes or life stressors have you experienced recently?

Are finances an area of concern for you? Y/N _____

If yes, what would you like to be different? _____

Is there anything you engage in regularly right now that you would like to stop? Y/N

If yes, please provide more detail below:

Family Psychiatric History

Has any of your family, immediate or extended; been diagnosed or suffer from any of the following conditions? (please indicate yes or no in the first column and then note the family member relationship (father, sister etc.) in the second column).

Condition	Yes/No	Family Member(s)
Addictions (alcohol, drugs, sex etc)		
Anxiety		
Bi-Polar Disorder		
Borderline Personality Disorder		
Childhood Abuse (physical, emotional or sexual)		
Depression	_____	_____
Domestic Violence	_____	_____
Eating Disorders	_____	_____
Narcissistic Personality Disorder	_____	_____
Obsessive Compulsive Disorder	_____	_____
Postpartum Depression	_____	_____
Post Traumatic Stress Disorder	_____	_____
Schizophrenia	_____	_____
Other _____	_____	_____
_____	_____	_____
_____	_____	_____

Do you suspect any of your family members of suffering from mental health problems even though they may have never been officially diagnosed or treated? Y/N
If yes, please provide the family member relationship (father, sister etc.) and briefly describe the circumstances leading you to believe they may have a problem.

Has any of your family members, immediate or extended; ever been hospitalized for physical or mental health issues? Y/N
If yes, please provide the family member relationship (father, sister etc) and briefly explain the nature of the problem, which required attention.

Have any of your family members, immediate or extended; ever attempted or committed suicide? Y/N
If yes, please provide the family member relationship (father, sister etc) and describe the events leading up to and the circumstances surrounding the situation.

I know that describing the information requested in this form may be very difficult and has the possibility to bring up many different feelings and emotions. I hope you will trust that your giving me this information will help me provide the highest level of mental health care and safety to you as you begin this journey. I will welcome the opportunity to process any difficult emotions these forms have stirred when I meet with you. Until then, thank you for your openness and I look forward to our time together.