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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 (*please note: to receive a student discount, please bring a copy of a current transcript to your first session.)*

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 your 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*

_____Difficulty Concentrating
_____Crying
_____Missing classes/work
_____Feeling helpless
_____Feeling uptight
_____Worrying
_____Feeling hopeless
_____Lying to others
_____Recent weight loss
_____Recent weight gain
_____Feelings of self-doubt
_____Sexual preoccupation
_____Feeling out of control
_____Feelings of guilt
_____Memory loss/blackout
_____Difficulty sleeping
_____Stealing
_____Uncontrollable Anger
_____Eating binges
_____Eating purges
_____Heavy drinking
_____Heavy substance abuse
_____Withdrawing socially
_____Nervous around others
_____Injuring self
_____Feeling afraid
_____Excessive spending
_____Recurring dreams/nightmares
_____Feelings of despair
_____Loneliness
_____Cutting
_____Excessive anxiety in social situations

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? _____

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.