

INTAKE FORM

Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information.

Please complete this form and bring to your first session.

Name: _____
(Last) (First) (Middle Initial)

Birth Date: _____ Age: _____ Gender: _____ SS#: _____

Marital Status: Never Married Separated
 Married Divorced
 Domestic Partnership Widowed

Name of Parent or Guardian (if under 18 years): _____

Please list any children and age: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone Land Line: () _____ May we leave a message Yes No

Cell/Other Phone () _____ May we leave a message Yes No

E-Mail: _____ May we email a message Yes No

Referred by (if any): _____

My Account Will Be: Self Pay Insurance

Insurance Company: _____

Subscriber ID# or Social Security Number of Insured: _____

Name of Insured: _____ Relationship: _____

Group Number: _____

Place of Employment: _____

Insured's Date of Birth: _____

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

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 to be 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?
