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: ____
(Last) (First) (Middle Initial)

Name of parent/guardian (if under 18 years): ______________________
(Last) (First) (Middle Initial)

Birth Date: ______ /______ /______ **Age**: __________ **Gender**: ______________

Marital Status:

☐ Never Married ☐ Domestic Partnership ☐ Married

☐ Separated ☐ Divorced ☐ Widowed

Length of Relationship (if applicable): ______________________________

Significant Other's Name (if applicable): ______________________________

Please List any Children / Age: ______________________________

Address: ____
(Street and Number)

____
(City) (State) (Zip)

Home Phone: ( )__________________ May we leave a message? ☐Yes ☐No

Cell Phone: ( )_______________ May we leave a voice mail and/or text message? ☐Yes ☐No

E-mail: ______________________________ May we email you? ☐ Yes ☐ No
*Please note: Email correspondence is not considered to be a confidential medium of communication.

Referred by (if any): ______________________ May we thank them?☐ Yes ☐ No

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?
☐ No ☐ Yes: Previous therapist/practitioner name: ______________________

Are you currently taking any prescription medication (psychiatric or other)?
☐ No
☐ Yes. Please list:

Medication	Dosage	Frequency	# Years Taken	Purpose of Med

GENERAL HEALTH AND MENTAL HEALTH INFORMATION (1= Very Poor, 10 = Very High)

1. **On a scale of 1-10, how would you rate your current physical health?** ________________

Please list any specific health problems you are currently experiencing:

____

2. **On a scale of 1-10, how would you rate your current sleeping habits?** ________________

Please list any specific sleep problems you are currently experiencing and when they started:

____

3. **How many times per week do you generally exercise?** ____________________________

What types of exercise do you participate in? ____________________________________

4. **Are you currently experiencing overwhelming sadness, grief or depression?**
☐ No
☐ Yes. Please describe: ____

For approximately how long? ____

5. **Are you currently experiencing anxiety, panic attacks or have any phobias?**
☐ No
☐ Yes. Please describe: ____

For approximately how long? ____

6. **Are you currently experiencing any chronic pain?**
□ No
□ Yes. Please describe ____

For approximately how long? ____

7. **How many nights / week do you drink alcohol?** ___________________________________

How many drinks a night? ____

8. **How often do you engage recreational drug use?**
☐ Daily ☐ Weekly ☐ Monthly ☐ Infrequently ☐ Never

9. **What significant life changes / stressful events have you experienced recently? Rate them 1-10:**

____ 1-10 Rating: ____________

____1-10 Rating:____________

FAMILY HISTORY:

In the section below check if there is a history of any of the following for you or any family members. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

	You √	**Family Member(s)** √	**List Family Member(s)**
Alcohol/Substance Abuse			
Anxiety			
Bipolar Disorder			
Depression			
Domestic Violence			
Eating Disorders			
Obesity			
Obsessive Compulsive Behavior			
Schizophrenia			
Suicide Attempts			
Traumatic Experience(s)			
Other (please specify) _______________			

Rate Your Relationship: Complete All That Apply **(10 = Best)**

Relationship	**Name**	**Rating (1-10)**	**Reason(s) for Rating**
Significant Other			
Child (Oldest)			
Child (Middle)			
Child (Youngest)			
Mother			
Father			
Sister			
Brother			
Friend			
Other __________			
Other __________			

ADDITIONAL INFORMATION:

1. **Are you currently employed?**
   ☐ No
   ☐ Yes. What is your occupation: ____

   Is there anything stressful about your current work? ______________________________

2. **Do you consider yourself to be spiritual or religious?**
   ☐ No
   ☐ 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?**

____

____

____

6. **What are you looking for in your therapist? Circle all that apply**.

Compassion	Empathy	Kindness	Active listening
Honesty	Experience	Realistic Approach	Validating
Sincerity	Confrontation	Trustworthiness	Optimism
Knowledge	Confidential	Homework	No Homework
Safe Person to Vent To	Identify My Issues	Confront My Behaviors	Give Me Hope