

# Intake Form

*Please provide the following information for our records. Leave blank any question you would rather not answer. Information you provide here is held to the same standards of confidentiality as our therapy.*

Name: \_\_\_\_\_  
(Last) (First) (Middle Initial)

Name of parent/guardian (if you are a minor):

\_\_\_\_\_  
(Last) (First) (Middle Initial)

Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Gender:

Marital Status: \_\_\_\_\_

Number of Children: \_\_\_\_\_

Local Address:

\_\_\_\_\_  
(Street and Number)

\_\_\_\_\_  
(City) (State) (Zip)

Home Phone: ( ) - May we leave a msg?

Cell/Other Phone: ( ) - May we leave a msg?

E-mail: \_\_\_\_\_ May we email you?

\*Please be aware that email might not be confidential.

yes! I would like to receive your email newsletter

Referred by: \_\_\_\_\_

Are you currently receiving psychiatric services, professional counseling or psychotherapy elsewhere?

Have you had previous psychotherapy?

Are you currently taking prescribed psychiatric medication (antidepressants or others)?

If Yes, please list: \_\_\_\_\_

If no, have you been previously prescribed psychiatric medication?

If Yes, please list: \_\_\_\_\_

### **Health and Social Information**

1. How is your physical health at present? (please circle)

Poor      Unsatisfactory      Satisfactory      Good      Very good

2. Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.):

3. Are you having any problems with your sleep habits?

4. How many times per week do you exercise?

Approximately how long each time?

5. Are you having any difficulty with appetite or eating habits?

If yes, check where applicable:

Have you experienced significant weight change in the last 2 months?

6. Do you regularly use alcohol?

In a typical month, how often do you have 4 or more drinks in a 24-hour period?

7. How often do you engage recreational drug use?

8. Have you had suicidal thoughts recently?

Have you had them in the past?

9. Are you currently in a romantic relationship?

If yes, how long have you been in this relationship?

On a scale of 1-10, how would you rate the quality of your current relationship?

10. In the last year, have you experienced any significant life changes or stressors:

**Have you ever experienced:**

Extreme depressed mood	yes/no
Wild Mood Swings	yes/no
Rapid Speech	yes/no
Extreme Anxiety	yes/no
Panic Attacks	yes/no
Phobias	yes/no
Sleep Disturbances	yes/no
Hallucinations	yes/no
Unexplained losses of time	yes/no
Unexplained memory lapses	yes/no
Alcohol/Substance Abuse	yes/no
Frequent Body Complaints	yes/no
Eating Disorder	yes/no
Body Image Problems	yes/no
Repetitive Thoughts (e.g., Obsessions)	yes/no
Repetitive Behaviors (e.g., Frequent Checking, Hand-Washing)	yes/no
Homicidal Thoughts	yes/no
Suicide Attempt	yes/no

**Occupational Information:**

Are you currently employed?

If yes, who is your current employer/position?

If yes, are you happy at your current position?

Please list any work-related stressors, if any:

**Religious/Spiritual Information:**

Do you consider yourself to be religious?

If yes, what is your faith?

If no, do you consider yourself to be spiritual?

**Family History**

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (circle any that apply and list family member, e.g., Sibling, Parent, Uncle, etc.):

<b>Difficulty</b>		<b>Family Member</b>
Depression	yes/no	
Bipolar Disorder	yes/no	
Anxiety Disorders	yes/no	
Panic Attacks	yes/no	
Schizophrenia	yes/no	
Alcohol/Substance Abuse	yes/no	
Eating Disorders	yes/no	
Learning Disabilities	yes/no	
Trauma History	yes/no	
Suicide Attempts	yes/no	

**Other Information:**

What do you consider to be your strengths?

What do you like most about yourself?

What are effective coping strategies that you've learned?

What are your goals for therapy?