Intake Form

Please provide the following information and answer the questions below. Please note that information provided here is considered confidential medical information.

Please fill out this form and bring it to your first session.

Name: ____
(Last) (First)

Name of parent/guardian (if under 18 years of age):

____
(Last) (First)

Birth Date: _______/_______/_______ **Age:** ___________

Address: ____
(Street and Number) (City) (State) (Zip code)

Home Phone Number: ( ) **May I leave a message ( ) Yes ( ) No**

Cell/Other Phone Number: ( ) **May I leave a message ( ) Yes ( ) No**

Were you Referred by anyone? If yes who referred you? ____________________________________

How did you learn about me? ____

General Health & Mental Health Information

1. Do you suffer from any known medical conditions?

____

2. How would you rate your current quality of sleep? (please circle one)

Good Fair Poor

Please list any specific sleep issues: ____

3. How would you rate your current appetite? (please circle one)

Good Fair Poor

Please list any specific appetite or diet issues: ____

4. Do you engage in routine physical activity/exercise and if so what kind?

____

5. Do you consume alcohol or drugs? (circle one for each category)

(Yes – Alcohol) (No – Alcohol) (Yes – Drugs) (No – Drugs)

If you answered yes to alcohol or drug consumption, please describe frequency of use:

____

6. Are you currently suffering from feelings of sadness, depression, or grief?

( ) Yes
( ) No
If yes, for approximately how long have you been experiencing this?

____

7. Are you currently suffering from feelings of anxiety, unease, phobias, or panic attacks?

( ) Yes
( ) No
If yes, for approximately how long have you been experiencing this?

____

8. Have you previously engaged in substance abuse or mental health counseling?

( ) No
( ) Yes
If yes, please list previous programs or providers and year that you were in treatment:

____

____

____

9. Are you currently taking any prescribed medications?

( ) No
( ) Yes
Please list: ____

10. Have you ever been prescribed psychiatric medications?

( ) No
( ) Yes
Please list: ____

Family & Intimate Relationship History:

1. Are you currently in a romantic relationship? ( ) No ( ) Yes
If yes, for how long: ______________________________

2. Are you satisfied with your current relationship or are you satisfied being single?

____

3. Please list any children and their ages:

____

____

4. Do you have close friends? (please circle one)

No Yes – Several Yes – a few

5. Do you ever feel like you are isolated or lack support from others? ( ) Yes ( ) No

6. Are you interested in improving any relationships in your life? ( ) No ( ) Yes
If yes, please specify: ____

7. In the section below please identify if there is family history of the following:

	Please Circle		List Family Member(s)
Alcohol/Substance Abuse	Yes	No	____________________________
Anxiety	Yes	No	____________________________
Depression	Yes	No	____________________________
Domestic Violence	Yes	No	____________________________
Other Mental Health Problems	Yes	No	____________________________
Suicide Attempts	Yes	No	____________________________

8. Is there anything you would like me to know about your family or your culture?

____

____

Additional Information

1. Are you currently employed? ( ) No ( ) Yes
If yes, please list your job title and employer:

____

2. What significant life changes or stressors have you been experiencing lately?

____

____

____

3. What do you consider to be your strengths as a person?

____

____

____

4. What do you consider to be some of your limitations or weaknesses?

____

____

____

5. Do you identify as a certain religion or spirituality? Is there anything you want me to understand about how your religion or spirituality may be part of your mental health?

____

____

6. What would you like to accomplish out of your time of therapy?

____

____