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I N T A K E F O R M

Please note: information you provide here is protected as confidential information. Please complete both sides of this form and bring it to your first session.

Today's Date: ____________________

Name: ____Birth Date: ______ /______ /______

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

Age: ________ Gender:______ Race/Ethnicity: _______________________________________

Address:____
(Street and Number)

____
(City) (State) (Zip)

Emergency Contact: ____
(Full Name) (Phone number)

☐ Never Married ☐ Domestic Partnership ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Please list any children/age(s):

____

Home Phone: ( ) ___________________May we leave a message? ☐ Yes ☐ No
Cell/Other Phone: ( ) ______________May we leave a 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 I have your permission to thank this person for the referral? ☐ Yes ☐ No
How did this person explain how I might be of help to you?

____

____

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

____

Have you ever been prescribed psychiatric medication?
☐ No ☐Yes, please list and provide dates:____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. Please list any specific health problems you are currently experiencing: ______________________
____
2. Please list any specific sleep problems you are currently experiencing:____
____
3. How many times per week do you generally exercise? ___________ For how long? ____________
4. Please list any concerns you have with your appetite, nutrition or eating patterns _______________
____
5. Are you currently experiencing overwhelming sadness, grief or depression?
☐ No ☐ Yes, for approximately how long? ____
6. Are you currently experiencing anxiety, panic attacks or have any phobias?
☐ No ☐ Yes, when did you begin experiencing this? ______________________________________
7. Are you currently experiencing any chronic pain?
☐ No ☐ Yes, please describe ____
8. How often do you drink alcohol? ________________ How much? __________________________
9. Recreational drug use? ☐ Daily ☐ Weekly ☐ Monthly ☐ Infrequently ☐ Never
10). 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, etc.).
Alcohol/Substance Abuse ☐ No ☐ Yes, who?______ Anxiety ☐ No ☐ Yes who? ___________________
Depression ☐ No ☐ Yes, who?_________________ Violence/Abuse ☐ No ☐ Yes, who?____________
Eating Disorders ☐ No ☐ Yes , who?________ ____Suicide Attempts ☐ No ☐ Yes , who?____________
Schizophrenia ☐ No ☐ Yes , who?____________________
Other __________❑ ☐ No ☐ Yes , who?______

ADDITIONAL INFORMATION:

1. Are you currently employed? ☐ No ☐ Yes, what is your current employment situation?
____
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
____