INTAKE FORM

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

Today's Date _____

Personal Identifying Information

Last Name: _____ First Name: _____

Date of Birth: _____ Age: _____

Gender: _____ Male _____Female Ethnic Background: _____

Who do you live with? _____

Home Address: _____

City: _____State: _____Zip Code: _____

Home Phone: _____ Cell Phone: _____

Email: _____

SSN: _____Referred by: _____

If Under 18, Parent/Guardian: _____

Emergency Contact: _____

Relation: _____Phone No: _____

Marital Status: _____ Single_____ Married_____ Divorced _____ Cohabitating

_____ Widowed _____ Separated _____ Other: _____

Children: ____ No Yes ____ How many: _____ Ages: _____

Employer Information:

Employer Name: _____ Phone No: _____

Length of Employment: _____ Job Title: _____

Employment Address: _____

_____

Mental Health History

Have you received previous psychotherapy/counseling in the past? ___No ___ Yes

When? _____ Where? _____

Name of treating doctor/counselor: _____

Outcome: _____

1. Are you currently experiencing anxiety, panic attacks, or have any phobias?
   ____No
   ____Yes
   If yes, when did you begin experiencing this? _____

2. Are you currently experiencing any chronic pain?

   ____No

   ____Yes

   If yes, please describe: _____

3. Do you drink alcohol more than once a week? _____No Yes _____
4. How often do you engage in recreational drug use?

   ____Daily ____Weekly ____Monthly ____ Infrequently ____Never

5. 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? _____
6. 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 Domestic Violence	yes/no	
Eating Disorders	yes/no	
Obesity	yes/no	
Obsessive Compulsive Behavior	yes/no	
Schizophrenia	yes/no	
Suicide Attempts	yes/no	

Are you currently taking any prescription medications? ____Yes ____No

Please list: _____

Have you ever been prescribed psychiatric medication? _____Yes ____No

Please list and provide dates: _____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

How would you rate your current physical health? (Please circle)

Poor Unsatisfactory Satisfactory Good Very Good

Please list any specific health problems you ae currently experiencing.

_____

How many times per week do you generally exercise? _____

What types of exercise to you participate in? _____

Please list any difficulties you experience with your appetite or eating patterns:

_____

Are you currently experiencing overwhelming sadness, grief, or depression?

_____Yes _____No

If yes, for approximately how long? _____

ADDITION INFORMATION

Are you currently employed? ____Yes ____ NO

If yes, what is your current employment situation? _____

Do you enjoy your work? Is there anything stressful about your current work?
_____
_____

Do you consider yourself to be spiritual or religious? _____ Yes _____ No

If yes, describe your faith or belief _____

_____

What do you consider to be some of your strengths? _____

_____
_____

What do you consider to b some of your weaknesses? _____

_____
_____
_____

What would you like to accomplish out of your time in therapy? _____

_____
_____