

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: Male Female

Address: _____
(Street and Number): (City) (State) (Zip)

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): _____

Insurance Provider Name: Ind. ID#: Gp Id#:

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you describe your current physical health (Please list any specific health problems and the names of treatment providers):

2. Please describe any mental or behavioral health therapy you may have received in the past:

3. How would you describe your current sleeping habits?

4. How many times per week do you generally exercise? _____

What types of exercise do you participate in _____

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

6. Are you currently experiencing overwhelming sadness, grief or depression? No Yes
If yes, for approximately how long? _____

7. Are you currently experiencing anxiety, panic attacks or have any phobias? No Yes
If yes, when did you begin experiencing this? _____

8. Please describe any history of alcohol or drug use:

9. Have you previously received any substance abuse treatment services?

No

Yes, previous therapist/hospital/facility: _____

10. Are you currently taking any prescription medication?

Yes

No

Please list: _____

11. Have you ever been prescribed psychiatric medication? Yes No

FAMILY AND INTIMATE RELATIONSHIP HISTORY:

1. 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? _____

Please list any children/age: _____

Please describe any relevant information regarding past intimate relationships:

2. Please describe any family history of the following:

Alcohol/Substance Abuse/ Mental health problems (including diagnosis) _____

Suicide Attempts: _____

Additional notes: _____

ADDITIONAL INFORMATION:

1. What significant life changes or stressful events have you experienced recently: _____

2. Are you currently employed? No Yes
If yes, what is your current employment situation:

3. What do you consider to be your strengths? _____

4. What do you consider to be your weaknesses? _____

5. What would you like to accomplish during your time in therapy? _____
