INTAKE FORM

Please answer all the questions below and bring the filled out form to your first initial session. Also, print or type your answers. All the information you provide here is protected as confidential information.

IDENTIFICATION INFORMATION

Name:

____

(Last) (First) (Middle)

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

____

(Last) (First) (Middle)

Birth Date: ______ /______ /______ Age: ________ Gender: □ Male □ Female

Marital Status: □ Never Married □ Domestic Partnership □ Married
□ Separated □ Divorced □ Widowed

Children/age: ____

Address: ____
(Street and number)

____
(City, State or Country, Zip Code)

Home Phone: ___________________________________ May a message be left? □ Yes □ No

Cell/Other Phone: _______________________________ May a message be left? □ Yes □ No

E-mail: ____ May an email be sent? □ Yes □ No
*Please note: Email correspondence is not considered to be a confidential medium of communication.

PROBLEM AND/OR ISSUES

Why did you decided to come to therapy and what significant life changes or stressful events have you experienced lately? ____
____
____
____
____
____

CURRENT PERSONAL FUNCTIONING STATUS

Are you currently in a romantic relationship?
□ No
□ Yes, for how long and rate it on a scale from 1-10 (10 being the highest)? ________________
____

Who in your life can you talk to if you are having problems or issues? _____________________
____

Are you employed?
□ No
□ Yes, with whom, what do you do, how long, and do you enjoy it? _______________________
____

How many times a week do you exercise and for how long? ______________________________
____

Do you eat a healthy diet?
□ No
□ Yes

What do you rate your self-esteem on a scale from 1-10 (10 being the highest)? ______________

What are your positive attributes or strengths? ____
____

MENTAL AND BEHAVIORAL HEALTH CHANGES

In the table below mark if there are any changes for you mentally or behaviorally.

Symptom	Distress Level			
	None	**Mild**	**Moderate**	**Extreme**
Mood/Irritability				
Sleep				
Psychomotor Skills				
Energy				
Focus/Concentration				
Memory				
Appetite				
Weight				
Sexual Interest				
Guilt				
Interest in Pleasurable Activities				
Hopeless				

Helpless				
Worthless				

Are you currently experiencing overwhelming sadness, grief, or depression?
□ No
□ Yes, name, describe, rate your symptoms on a scale from 1 to 10 (10 being the highest), and for approximately how long? ____

____

Are you currently experiencing anxiety, panic attacks, or have any phobias?
□ No
□ Yes, name, describe, rate your symptoms on a scale from 1 to 10 (10 being the highest), and for approximately how long? ____

____

Are you currently believing, hearing, tasting, feeling or seeing things others don't?
□ No
□ Yes, name, describe, rate your symptoms on a scale from 1-10 (10 being the highest), and for approximately how long? ____

____

MEDICAL INFORMATION

Do you have any medical history?
□ No
□ Yes, list medical diagnosis(s) and date(s):____

____

How would you rate your current physical health?
□ Poor □ Unsatisfactory □ Satisfactory □ Good □ Very good

List any specific health problems you are currently experiencing: ______________________

____

Are you currently experiencing any chronic pain?
□ No
□ Yes, where, for approximately how long, and rate it on a scale of 1-10 (10 being the highest)?

____

____

Are you currently taking any prescription medication or supplements?
□ No
□ Yes, list name and who prescribed: ____

____

PSYCHIATRIC INFORMATION

Are you currently taking any psychiatric prescription medication?
□ No
□ Yes, list name and who prescribed: ____
____

In the past have you been prescribed psychiatric medication?
□ No
□ Yes, list name(s), date(s) and who prescribed: ____
____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?
□ No
□ Yes, list with whom and where you received services and date(s): ________________________
____

FAMILY HISTORY

In the table below list the family member or members who have experienced these problems or issues. (For example, mom, dad, brother, sister, grandfather, grandmother, aunt, uncle, and child).

Item	No	Yes	Family Member
Alcohol or Substance Abuse			
Anxiety			
Depression			
Obsessive Compulsive Behavior			
Schizophrenia			
Bipolar			
Abuse (Verbal, Emotional, Sexual, and/or Physical)			
Eating Disorders			
Suicide Attempts			
Learning Disability			

SUBSTANCE/ALCOHOL/HABITS

In the table below mark if you have had any problems or issues.

Item	No	Yes
Current Problem Illicit Drug Use		
History of Problem Illicit Drug Use		
Current Problem Alcohol Use		
History of Problem Alcohol Use		
History of ARIs, DUIs, etc.		
Problem Tobacco Use		
Problem Caffeine Use		
Problem Gambling		
Problem Gaming, Online, and/or Porn		
Problem Legal		
Problem Financial		

RISK ASSESSMENT

In the table below mark if you had have any thoughts or behaviors.

Item	No	Yes
History of Suicidal Ideation		
History of Suicidal Planning		
History of Suicidal Gestures		
History of Suicidal Attempts		
Close friends or family members who have attempted or completed suicide		
History of intentionally hurting anyone or intentionally destroying property		
History of being arrested for violent behavior		
Current intentions or urges to engage in any above behaviors		
History of impulsive or risk-taking behaviors		

____ ____________________

Patient’s signature or patient’s parent/guardian if under 18 Date

____

Printed name of patient or parent/guardian