I N T A K E F O R M

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

Please **PRINT** this form, complete it and bring it to your first session.

Name: _____
(Last) (First) (Middle Initial)

Birth Date: _____ /_____ /_____ Age: _____ Gender: □ Male □ Female

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

□ Divorced □ Widowed

Address: _____
(Street and Number)

_____
(City) (State) (Zip)

Home Phone: ( ) May I leave a message? □ Yes □ No

Cell/Other Phone: ( ) May I leave a message? □ Yes □ No

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

Referred by (if any): _____

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

Are you currently taking any prescription medication?
□ Yes
If yes, name and phone number of prescribing MD:_____
□ No

Please list medication(s): _____

_____

Have you ever been prescribed psychiatric medication in the **past**?
□ Yes
□ No

Please list and provide dates: _____

_____

With whom do you live? (please list all members of your household , including pets)

_____

_____

Is anyone in your current household facing any physical/mental health challenges? If so, please describe:

_____

_____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. IN GENERAL, how would you rate your **overall** physical health? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please describe any **specific** health problems you were treated for in the **past**, including surgeries:

_____

Please describe any 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? _____

What types of exercise to you participate in _____

4. Please list any difficulties you experience with your appetite or eating patterns (past or present):

_____

5. Are you currently experiencing overwhelming sadness, grief or depression?
□ No
□ Yes

If yes, for approximately how long? _____

6. Are you currently experiencing anxiety, panic attacks or have any phobias?
□ No
□ Yes

If yes, when did you begin experiencing this? _____

7. Are you currently experiencing any chronic pain?
□ No
□ Yes

If yes, please describe _____

8. Do you drink alcohol more than once a week? □ No □ Yes

9. How often do you engage in recreational drug use? □ Daily □ Weekly □ Monthly
□ Infrequently □ Never

10. 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? _____

11. What significant life changes or stressful events have you experienced in the last year:

_____

FAMILY OF ORIGIN 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	
Bipolar Disorder	yes/no	
Depression	yes/no	
Domestic Violence	yes/no	
Eating Disorders	yes/no	
Obesity	yes/no	

Obsessive Compulsive Behavior	yes/no
Schizophrenia	yes/no
Suicide Attempts	yes/no

ADDITIONAL INFORMATION:

1. Are you currently employed? □ No □ Yes

If yes, what is your current employment situation:

_____

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

_____

_____

2. Are you a veteran? If yes, when and where did you serve?

_____

3. Do you consider yourself to be spiritual or religious? □ No □ Yes

If yes, describe your faith or belief:

_____

4. What do you consider to be some of your strengths?

_____

_____

_____

_____

5. What do you consider to be some of your limitations?

_____

_____

_____

_____

6. What is it that brings you into therapy at this time?

_____

_____

7. Is there anything else you'd like to add?

_____

_____