I N T A K E F O R M

Please provide the following information and answer the questions below. Please note:
The information you provide here is protected as confidential information.
Please fill out this form and bring it to your first session.

DATE_____

Name: _____

Address: _____

City _____ State _____ Zip code_____

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

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

Social Security Number_____
Client Employed by_____
Work Phone Number _____ May we contact you at work? _____

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.

Emergency Contact Name_____
Emergency Contact Phone Number_____

Spouse or Responsible party_____
Address_____City_____State_____Zip_____
SSN_____ Relationship to client_____

Please list any children/age: _____

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

□ No

Please list: _____

_____

Have you ever been prescribed psychiatric medication?
□ Yes
□ No

Please list and provide dates: _____

_____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:

_____

2. How would you rate your current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

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

_____

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 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 recently:

12. What is your birth order? Please write the order of your siblings, starting with the first born to the last born. Use B for brothers, S for sisters. Circle your own position. Example S (B) S

Please do the same for your spouse, if applicable

13. Is (Was) the family you grew up in intact? (no divorces) Yes _____ No _____

14. How frequently do you have contact with your parents? (Please Circle)
Daily Weekly Monthly 4xyear Every 6 months 1xyear

15. Are you the child in the family that lives closest to home? Yes _____ No _____

16. Are you the child that lives the farthest from home? Yes _____ No _____

17. Is the family you live in now intact? (have never been divorced) Yes _____ No_____

18. Do you have contact with your children? Please circle
Daily weekly monthly 4xyear every 6 months 1xyear

19. Do you have any legal behavioral problems? (DUI's, alcoholism, probation, juvenile court)
Yes _____ No_____

20. Have you experienced the: (Circle and provide date when event occurred)
Death of your mother
Death of your father
Death of sibling
Death of grandmother
Death of grandfather
Birth of child
Loss of physical function

Death/removal of child
Loss of job
Infertility problems
Marriage
Divorce

21. Does your mother have ongoing health, relationship, or behavioral problems? If so, circle which type.

22. Does your father have ongoing health, relationship, or behavioral problems? Is so, circle which type.

23. Please list number of medication and dosages

Medications	Dosage
_____	_____
_____	_____
_____	_____
_____	_____

24. Do you have a current medical diagnosis? Yes _____ No_____

Please list diagnosis_____
When were you diagnosed?_____

25. Please list any hospitalizations with the past five years

Hospitals	Duration	Diagnosis
_____	_____	_____
_____	_____	_____