INTAKE FORM

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 completely and bring it with you to your first session.

Name:_____
(nickname)_____
Name of parent/guardian (if under 18 years).
_____
Birthdate: _____/_____/_____Age:_____ Gender:_____ Marital Status: _____years_____
Are you currently in a romantic relationship? If yes, how long?
_____
On a scale of 1-10, how would you rate your relationship and why?
_____
Children/Ages:
_____

Address:_____
(Street number, apt. #, City, State, ZipCode)
Phone number/s: _____May we leave a message? _____ (please indicate if cell, home, or work)
Email: _____May we email you?_____ *Please note: Email correspondence is not considered to be a confidential medium of communication, therefore it should only be used for scheduling purposes only.

Employer or School: _____ Do you enjoy your work? Is there anything stressful about your current work?_____Military_____
Referred by (if any):
_____ Will you need us to communicate with anyone outside of therapy office? _____
Have you previously received any type of mental health services (therapy, counseling, hospitalization, marriage counseling, etc.?
_____
(Please list any previous therapists or treatment centers)
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:
_____
_____
Any chronic pain?_____if yes, please describe:
_____ How would you rate your sleep habits? (please circle)
Poor Unsatisfactory Satisfactory Good Very good
Any specific sleep problems:
_____
How many times per week do you exercise?____ What type?_____

Any difficulties with appetite or eating patterns?
_____History_____

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

If yes, for approximately how long? _____Are you currently experiencing anxiety, panic attacks, or have any phobias? (Afraid of dogs or cats?)____ If yes, when did you begin to experience this?
_____

Are you taking any prescribed medications? Please list:

_____
Past psychiatric medications?
_____
Do you drink alcohol? _____ If so, how often?_____

How often do you engage in recreational drug use? Please circle: daily/weekly/weekends/monthly/never

What significant life changes or stressful events have you experienced recently?
_____
_____
_____
List any significant family of origin (parents, siblings, grandparents) history: Are parents still alive? Married? Siblings?
_____
_____
_____
Any suicide attempts? If so, how many? _____Family? _____
Do you consider yourself to be religious? If so, what is your faith, religion and upbringing?
_____
What do you consider to be some of your strengths?
_____
_____
What do you consider to be some of your weaknesses?
_____
_____
What would you like to accomplish out of your time in therapy?
_____
_____
Do you have any questions for me?
_____
_____

Signature_____
If under 18, parent must sign form.