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INTAKE FORM

PLEASE PROVIDE THE FOLLOWING INFORMATION AND ANSWER THE QUESTIONS BELOW. PLEASE NOTE: INFORMATION YOU PROVIDE HERE IS PROTECTED AS CONFIDENTIAL INFORMATION.

Name: _____

Address:_____

_____

Birth Date: _____ Age: _____ Gender: Male Female

Marital Statues: _____ Never Married _____Domestic Partnership

_____Married _____Separated _____Divorced _____Widowed

Please list any children/age: _____

_____

Home Phone: _____ May I leave a message? _____

Cell/Other _____ May I leave a message? _____

Email _____ Is it private? _____

How you found me:

Referred by: _____ ____ Website? _____

Have you previously received any type of mental health services? _____

Are you currently taking any prescription medication? _____

Have you ever been prescribed psychiatric medication? _____

If yes, please list and provide dates: _____

_____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health?

Poor Unsatisfactory Satisfactory Good Excellent

Please list any specific health problems you are currently experiencing:

2. How would you rate your current sleeping habits?

Poor Unsatisfactory Satisfactory Good Excellent

Please list any specific sleep problems you are currently experiencing:

3. Please describe your exercise routine, if any:

4. Are you currently experiencing overwhelming sadness, grief or depression?

_____ Yes _____No

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

_____

_____

6. Are you currently experiencing:

_____ Anxiety _____Panic Attacks _____Phobias

7. Are you currently experiencing chronic pain?

_____ Yes _____No

8. Do you drink alcohol more than once a week? _____Yes _____No

9. How often do you engage in recreational drug use?

_____Daily _____Weekly _____Monthly _____Seldom _____Never

10. Are you currently in a romantic relationship? _____Yes _____No

If yes, for how long? _____ Please rate your relationship on a scale, 1-10 _____

11. What significant life changes or stressful events have you experienced recently?:

FAMILY MENTAL HEALTH HISTORY:

In the section below, please identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you.

	Please Circle		List Family Member
Alcohol/Substance Abuse	Yes	No	
Anxiety	Yes	No	
Depression	Yes	No	
Bipolar	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 _____ Yes _____ No

If yes, what is your current employment situation?

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

2. Do you consider yourself to be spiritual or religious? _____Yes _____No

If yes, describe your faith or belief:

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

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

5. What would you like to accomplish out of your time in therapy?