INTAKE FORM

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

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

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

____
(Last) (First) (Middle Initial)

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

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

Please list any children/age: ____

____

____
Address:

____
(Street and Number)

____
(City) (State) (Zip)

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.

Referred by (if any):

____

Presenting problem (frequency, duration, intensity):

____

Are you currently receiving psychiatric services, professional counseling or psychotherapy elsewhere? □ Yes □ No

Have you had previous psychotherapy?
□No □Yes Previous therapist's name____

Are you currently taking prescribed psychiatric medication (antidepressants or others)?
□Yes □No If Yes, please list: ____

If no, have you been previously prescribed psychiatric medication?
□Yes □No If Yes, please list: ____

HEALTH AND SOCIAL INFORMATION

1. How is your physical health at present? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

2. Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.):

____

____

3. Are you having any problems with your sleep habits? □ No □ Yes

If yes, check where applicable:
□ Sleeping too little □ Sleeping too much □ Poor quality sleep
□ Disturbing dreams □ Other _________________________

4. How many times per week do you exercise? __________
Approximately how long each time? __________

5. Are you having any difficulty with appetite or eating habits? □ No □ Yes
If yes, check where applicable: □ Eating less □ Eating more □ Binging □ Restricting

Have you experienced significant weight change in the last 2 months? □ No □ Yes

6. Do you regularly use alcohol? □ No □ Yes
In a typical month, how often do you have 4 or more drinks in a 24-hour period? ______

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

8. Have you had suicidal thoughts recently?
□ Frequently □ Sometimes □ Rarely □ Never

Have you had them in the past? □ Frequently □ Sometimes □ Rarely □ Never

9. Are you currently in a romantic relationship? □ No □ Yes
If yes, how long have you been in this relationship? __________________

On a scale of 1-10, how would you rate the quality of your current relationship? ______

10. In the last year, have you experienced any significant life changes or stressors:

____

____

____

Have you ever experienced:

Extreme depressed mood: □ No □ Yes

Wild Mood Swings: □ No □ Yes

Rapid Speech: □ No □ Yes

Extreme Anxiety: □ No □ Yes

Panic Attacks: □ No □ Yes

Phobias: □ No □ Yes

Sleep Disturbances: □ No □ Yes

Hallucinations: □ No □ Yes

Unexplained losses of time: □ No □ Yes

Unexplained memory lapses: □ No □ Yes

Alcohol/Substance Abuse: □ No □ Yes

Frequent Body Complaints: □ No □ Yes

Eating Disorder: □ No □ Yes

Body Image Problems: □ No □ Yes

Repetitive Thoughts: □ No □ Yes
(e.g., obsessions)

Repetitive Behaviors: □ No □ Yes
(e.g., frequent checking, hand-washing)

Homicidal Thoughts: □ No □ Yes

Suicide Attempt: □ No □ Yes

OCCUPATIONAL/ACADEMIC INFORMATION:

Are you currently employed? □ No □ Yes

If yes, who is your current employer/position?____________________________________

If yes, are you happy at your current position?___________________________________

Are you currently a student? □ No □ Yes If yes, full-time or part-time?______________

Please list any work-related and/or academic stressors, if any:

____

____

RELIGIOUS/SPIRITUAL INFORMATION:

Do you consider yourself to be religious? □ No □ Yes

If yes, what is your faith?

____

If no, do you consider yourself to be spiritual? □ No □ Yes

FAMILY MENTAL HEALTH HISTORY:

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following?

Difficulty	Family Member
Depression: □ No □ Yes	____________________________________
Bipolar Disorder: □ No □ Yes	____________________________________
Anxiety Disorders: □ No □ Yes	____________________________________
Panic Attacks: □ No □ Yes	____________________________________
Schizophrenia: □ No □ Yes	____________________________________
Alcohol/Substance Abuse: □ No □ Yes	____________________________________
Eating Disorders: □ No □ Yes	____________________________________
Learning Disabilities: □ No □ Yes	____________________________________
Trauma History: □ No □ Yes	____________________________________
Suicide Attempts: □ No □ Yes	____________________________________
Domestic Violence: □ No □ Yes	____________________________________

OTHER INFORMATION:

What do you consider to be your strengths?

____

____

____

____

____

____

What do you like most about yourself?

What are effective coping strategies that you’ve learned?

What are your goals for therapy?

DIAGNOSIS:

Provider:

Signature

Date