Intake Form

Please answer the following confidential questions to help us better understand and meet your needs. This form needs to be completed before your first session. ***Thank you.***

Today's Date _____

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

Address _____
(Street and Number)

_____
(City) (State) (Zip)

Is it OK to mail any correspondence to this address? [ ] Yes [ ] No

Contact Number _____ May we leave a message? [ ] Yes [ ] No

Other Number _____ May we leave a message? [ ] Yes [ ] No

*Email _____ May we email you? [ ] Yes [ ] No
(*Please note that email correspondence is not a confidential medium of communication.)

Birth Date _____ Gender: [ ] Male [ ] Female

Name of parent/guardian (if under age of 18 or applicable): _____

Race: [ ] White/European descent [ ] Black/African-American/Caribbean [ ] Native American [ ] Asian
[ ] Middle Eastern [ ] Hispanic/Latino/Spanish descent [ ] Other _____

Highest Education (Current or Achieved) _____

Marital Status: [ ] Never married [ ] Separated [ ] Married [ ] Divorced [ ] Domestic Partner [ ] Widowed

Please list any children & age: _____
_____

Referred by or how did you hear about us (if any) _____
(Please note that no referral source will be contacted or informed of your visit(s) without your written approval unless other arrangements have been agreed upon.)

Previous History

1. Have you previously received any type of mental health services (psychotherapy, counseling, medication management (psychiatric services), etc.)? [ ] No [ ] Yes, Therapist or doctor: _____
   Diagnosis(es) given _____
2. What was helpful? _____
   What was not helpful? _____
3. Do you have any allergies? _____ Please list: _____
4. Are you currently taken or ever been prescribed psychotropic medications (i.e., mood stabilizer, anti-depressants, anti-anxiety, memory aid, sleeping aid)? [ ] Yes [ ] No Please list medications & date use:
   _____
   _____
5. Are you currently taking any other prescription medication(s)? [ ] Yes [ ] No Please list: _____
   _____

General & Mental Health

1. What current symptom(s) or presenting issue(s) brought you in today? _____
   _____
2. Have you seen your Primary Care Physician (PCP) within the last year (past 12months)? [ ] Yes [ ]No
3. How would you rate your current physical health? [ ]Excellent [ ] Good [ ]Satisfactory [ ] Fair [ ] Poor
   Please list any current health problems you are experiencing: _____
   _____
4. How would you rate your current sleeping habits? [ ] Excellent [ ] Good [ ]Satisfactory [ ] Fair [ ] Poor
   Please list any specific sleep problems you are currently experiencing: _____
   _____
5. Has your appetite or eating habits changed? [ ] Yes [ ] No If so, how? _____
   _____
6. Are you currently experiencing any chronic pain? [ ] Yes [ ] No If yes, describe: _____
   _____
7. How many times per week do you exercise? _____
   What types of exercise do you engage in? _____
8. Are you currently experiencing overwhelming sadness, grief or depression? [ ] No [ ] Yes If so, for approximately how long? _____
   _____
9. Are you currently experiencing panic attacks, excessive worry, anxiety, or have any phobias? [ ]Yes [ ]No
   If yes, when did you begin experiencing this? _____
10. Do you drink alcohol? [ ] Yes [ ] No If so, how often? _____ How much? _____
11. Do you smoke or use tobacco products? [ ] Yes [ ] No If so, what do you use? _____
    How often? _____ How much? _____
12. How often do you engage in recreational drug use? [ ] Yes [ ] No
    [ ] Daily [ ] Weekly [ ] Monthly [ ] Never [ ] Other: _____
13. Are you currently in a romantic relationship? [ ] Yes [ ] No If so, for how long? _____
    On a scale of 1-10 (with 10 being "Excellent"), how would you rate your relationship? _____
14. What significant life changes or events have you recently experienced? _____
    _____

Family Mental Health History

Below identify any family history of the following. If yes, please indicate the relationship to you (ex. Self, Father, sister, uncle, grandmother, etc.) and include any personal diagnosis(es) and/or symptom(s).

	Circle one	List Relationship
Alcohol/Substance Abuse	Yes/No	
Anxiety	Yes/No	
Bipolar	Yes/No	
Delusions	Yes/No	
Dementia	Yes/No	
Depression	Yes/No	
Domestic Abuse	Yes/No	
Eating Disorders	Yes/No	
Hallucinations	Yes/No	
Obsessive Compulsive Behavior	Yes/No	
Schizophrenia	Yes/No	
Self-Mutilation (i.e. cutting)	Yes/No	
Sexual Abuse	Yes/No	
Suicide Attempt(s)	Yes/No	

Additional Information

1. Have you experienced any traumatic events such as accident(s), assault, combat, rape, significant loss that you recall? [ ] Yes [ ] No If so, explain: _____
   _____
2. Are you currently employed? [ ]Yes [ ]No
   If yes, where are you employed? _____
   Present or recent employment status? [ ] Part-time [ ] Full-time [ ] Student [ ] Other: _____
   Do you enjoy your work? _____ If yes, what do you enjoy? _____
   _____
   Is there anything stressful about your current work? _____
   _____
3. Do you consider yourself to be spiritual or religious? [ ] Yes [ ]No
   If yes, describe your faith or belief: _____
   _____
4. What are your strengths? _____
   _____
   _____
   _____
5. What do you consider your areas for growth or weaknesses? _____
   _____
   _____
   _____
6. What would you like to accomplish from your time (goals) in therapy here? _____
   _____
   _____
   _____
   _____
   _____

****

Emergency Contact(s):
These individuals will <u>only</u> be notified in the event of an emergency.

1. Name _____

   Relationship to Client: _____ Contact # _____

2. Name _____

   Relationship to Client: _____ Contact # _____