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I N T A K E F O R M

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: ____

Address: _____
(Street and Number)

(City) (State) (Zip)

Cell: _____ May I leave a message? ☐ Yes ☐ No

May I text you? ☐ Yes ☐ No

E-mail: _____ May I email you? ☐ Yes ☐ No

*Please note: Email, text, and voicemail correspondence is not considered to be a confidential medium of communication.

Referred by: _____

Marital Status:

☐ Never Married ☐ Domestic Partnership ☐ Married ☐ Separated

☐ Divorced ☐ Widowed

Name of Partner/Spouse: _____ Years together: _____

Number of Marriages: _____ Number of Divorces: _____

**On a scale of 1-10, how would you rate your relationship? _____

Please list any children/age:

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

Other: _____

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

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

☐ No

☐ Yes, previous therapist/practitioner: _____

What was your experience? _____

What medications or supplements are you currently on?

Please list: _____

FAMILY MENTAL HEALTH HISTORY:

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

	Please Circle	List Family Member
Alcohol/Substance Abuse	yes/no	
Anxiety	yes/no	
Depression	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	

Mother's name: _____

Age: _____ Deceased age: _____ Cause of death: _____ Supportive? _____

Father's name: _____

Age: _____ Deceased age: _____ Cause of death: _____ Supportive? _____

Sibling's name: _____

Age: _____ Deceased age: _____ Cause of death: _____ Supportive? _____

Sibling's name: _____

Age: _____ Deceased age: _____ Cause of death: _____ Supportive? _____

Sibling's name: _____

Age: _____ Deceased age: _____ Cause of death: _____ Supportive? _____

Personal History

I was sexually abused as a child _____ by whom: _____

I was physically abused as a child _____ by whom: _____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

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

Poor Unsatisfactory Satisfactory Good Very good

Please check the right answers:

- ☐ Headaches
- ☐ Fatigue
- ☐ Dizziness
- ☐ Hives, rashes, skin disorders
- ☐ Rapid heartbeats
- ☐ Joints/muscles pain
- ☐ Allergies to _____

Please list any specific health issues that you are being treated for or you are currently experiencing:

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

Poor Unsatisfactory Satisfactory Good Very good

Please check the right answers:

- ☐ Can't get to sleep
- ☐ Easy to go to sleep but wake up several times during the night
- ☐ Sleep more than 8-10 hours a day

Please list any specific sleep problems you are currently experiencing:

3. How many times per week do you generally exercise? _____

Types of exercise to you participate in _____

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

Please check the right answers:

- ___ Acid Reflex
- ___ Ulcers
- ___ Irritable Bowel Syndrome
- ___ Nausea and/or Vomiting
- ___ Diarrhea
- ___ Constipation
- ___ Bloating
- ___ Binge eating
- ___ Restricted eating
- ___ Try to eat Organic
- ___ Vegetarian
- ___ Vegan
- ___ Other _____

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

- ☐ No
- ☐ Yes

If yes, for approximately how long? _____

Please check the right answers:

- ___ I have attempted suicide _____ times
- ___ I have never attempted suicide
- ___ I think about suicide often
- ___ I have a plan for suicide, it is: _____
- ___ I have been hospitalized for a psychiatric condition _____ times

Name of hospital/s: _____

6. Are you currently experiencing anxiety, panic attacks or have any phobias?

- ☐ No
- ☐ Yes

If yes, when did you begin experiencing this? _____

Please check the right answers:

- ___ Poor memory
- ___ Confusion
- ___ Poor concentration
- ___ Difficulty making decisions
- ___ Mood swings
- ___ Anger, irritability
- ___ Sense of despair

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

What do you drink? _____

9 Drug History

Ever Used? Ever a Problem? Age of 1st Use when last used?

Alcohol	Yes	No	Yes	No
Sleeping pills	Yes	No	Yes	No
Benzodiazepines (Ativan, Xanax, Klonopin, Valium, etc..)	Yes	No	Yes	No
Caffeine	Yes	No	Yes	No
Cocaine	Yes	No	Yes	No
Ecstasy (MDMA)	Yes	No	Yes	No
Glue	Yes	No	Yes	No
Heroin	Yes	No	Yes	No
Other inhalants (Paint, whiteout)	Yes	No	Yes	No
LSD	Yes	No	Yes	No
Marijuana or hashish	Yes	No	Yes	No
Methadone	Yes	No	Yes	No
Methamphetamine	Yes	No	Yes	No
Mescaline	Yes	No	Yes	No
Mushrooms	Yes	No	Yes	No
Nicotine	Yes	No	Yes	No
Opiates (pain pills)	Yes	No	Yes	No
Opium	Yes	No	Yes	No
PCP	Yes	No	Yes	No
Peyote	Yes	No	Yes	No
Steroids	Yes	No	Yes	No
Steroid creams for skin	Yes	No	Yes	No

Please check the right answers:

_____ I have gone to _____ rehabs
_____ I need rehab
_____ I am sober and have how much sobriety: _____
_____ I go to a 12 Step Program named: _____
_____ I have a sponsor
_____ I go to _____ meetings a week

Names of Rehabs and year attended (list most recent) :

Month: _____ Year: _____ Name: _____

Month: _____ Year: _____ Name: _____

Month: _____ Year: _____ Name: _____

Month: _____ Year: _____ Name: _____

ADDITIONAL INFORMATION:

Are you currently employed? ☐ No ☐ Yes

What is your job title and name of employer?

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

Do you consider yourself to be spiritual or religious? ☐ No ☐ Yes

If yes, describe your faith or belief:

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

Signature: _____ Date: _____

Print Name: _____