# I N T AK E  F O R M

Please provide the following information for our records. Leave blank any question you would rather not answer. Information you provide here is held to the same standards of confidentiality as our therapy.

Please print out this form and bring it to your first session or allow yourself 30 minutes prior to your appointment to complete the form in the office.

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

Name of parent/guardian (if you are a minor):

(Last) (First) (Middle Initial)

Birth Date: _____ /_____ /_____ Age: _____ Gender: . Male . Female
Marital Status:

. Never Married . Partnered . Married . Separated . Divorced . Widowed
Number of Children: _____
Local Address: _____
(Street and Number)

(City) (State) (Zip)
Home Phone: ( ) -May we leave a msg? .Yes .No
Cell/Other Phone: ( ) -May we leave a msg? .Yes .No

E-mail: _____ May we email you? .Yes .No
*Please be aware that email might not be confidential.

How did you learn of my services?
Health Care Provider (Name)_____
Internet (Please be as specific as you can, eg. google ads, psychology today,etc.)_____
Other_____

Referred by: _____

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

Have you had previous psychotherapy?

.No
.Yes, at 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 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 yes/no
Wild Mood Swings yes/no
Rapid Speech yes/no
Extreme Anxiety yes/no
Panic Attacks yes/no
Phobias yes/no
Sleep Disturbances yes/no
Hallucinations yes/no
Unexplained losses of time yes/no
Unexplained memory lapses yes/no
Alcohol/Substance Abuse yes/no
Frequent Body Complaints yes/no
Eating Disorder yes/no
Body Image Problems yes/no

Repetitive Thoughts (e.g., Obsessions) yes/no
Repetitive Behaviors (e.g., Frequent Checking, Hand-Washing) yes/no
Homicidal Thoughts yes/no
Suicide Attempt yes/no

OCCUPATIONAL INFORMATION:
Are you currently employed? . No .Yes
If yes, who is your current employer/position? _____

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

Please list any work-related 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? (circle any that apply and list family member, e.g.,

Sibling, Parent, Uncle, etc.):

Difficulty Family Member
Depression yes/no
Bipolar Disorder yes/no
Anxiety Disorders yes/no
Panic Attacks yes/no
Schizophrenia yes/no

Alcohol/Substance Abuse yes/no
Eating Disorders yes/no
Learning Disabilities yes/no
Trauma History yes/no
Suicide Attempts yes/no

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?