

# Intake Form

Please provide the following information and answer the questions below. Please note: Information you provide here is protected as confidential information.

Patient's name: \_\_\_\_\_ Name of parent/guardian (if under 18): \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Please list any children (include ages): \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ May we leave a message? ☐ Yes ☐ No

Cell/other Phone: \_\_\_\_\_ May we leave a message? ☐ Yes ☐ No

Email: \_\_\_\_\_ May we email you? ☐ Yes ☐ No \*Please note: Email

correspondence is not considered to be a confidential medium of communication.

Referred by (if any): \_\_\_\_\_ Have you previously received any type of mental health services (psychotherapy, psychiatric services, ect)? ☐ No ☐ Yes, previous therapist/practitioner: \_\_\_\_\_

Are you currently taking any prescription medication? ☐ No ☐ Yes, please list: \_\_\_\_\_

Have you ever been prescribed psychiatric medication? ☐ No ☐ Yes, please provide details: \_\_\_\_\_

## General Health and Mental Health Information

1. How would you rate your current physical health?

☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very Good

Please list any specific health problems you are currently experiencing: \_\_\_\_\_

2. How would you rate your currently sleeping habits?

☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very Good

Please list any specific sleep problems you are currently experiencing: \_\_\_\_\_

3. How many times per week do you generally exercise and what types of exercise do you participate in? \_\_\_\_\_

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

Please describe a typical breakfast, lunch and dinner including beverages:

Breakfast: \_\_\_\_\_

Lunch: \_\_\_\_\_

Dinner: \_\_\_\_\_

5. Are you currently experiencing overwhelming sadness, grief or depression? ☐No ☐Yes

If yes, for approximately how long? \_\_\_\_\_

6. Are you currently experiencing anxiety, panic attacks, or have any phobias? ☐No ☐Yes

If yes, when did you begin experiencing this? \_\_\_\_\_

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

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

☐Daily

☐Weekly

☐Monthly

☐Infrequently

☐Never

10. Are you currently in a romantic relationship? ☐No ☐Yes. If yes, for how long? \_\_\_\_\_

On a scale of 1-10 how would you rate your relationship? \_\_\_\_\_

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

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### **Additional Information**

1. Are you currently employed? ☐No ☐Yes If yes, what is your current employment situation? \_\_\_\_\_

\_\_\_\_\_

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

\_\_\_\_\_

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

If yes, please 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? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please list the major problems that you would like help with in therapy, and rate the severity of each one according to the scale below:

1-----2-----3-----4-----5-----6-----7-----8-----9-----10

Not a problem

Mild Problem

Moderate problem

Severe Problem

Couldn't be Worse

**Rating:**

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

Briefly describe what motivated you to seek therapy at this time (rather than some other time earlier or later): \_\_\_\_\_

\_\_\_\_\_

6. Do you have any serious medical conditions ☐No ☐Yes If yes, please describe: \_\_\_\_\_

Problems with: ☐Headaches ☐Indigestion ☐Diarrhea ☐Frequent Urination ☐Shortness of Breath

☐Body Aches/ Pain ☐Circulation ☐Menstrual Problems

In the past year, how many... Visits to doctor: \_\_\_\_\_ Sick Days: \_\_\_\_\_ Alcoholic Drinks/days: \_\_\_\_\_

7. Current Stressful Events: ☐Legal ☐Financial ☐Family Problems ☐Family Illness

☐Other: \_\_\_\_\_ Are you in an abusive relationship: ☐No ☐Somewhat ☐Yes

Recent losses (Jobs, relationships or difficult changes): \_\_\_\_\_

8. Please give a rough estimate of how many **hours per week** you spend doing the following **in a typical week**:

Working in your primary job: \_\_\_\_\_ Parenting/Caretaking of others: \_\_\_\_\_

Doing household chores, bills, ect: \_\_\_\_\_ Watching TV or Movies: \_\_\_\_\_

Physical recreation or exercise of some kind: \_\_\_\_\_ Hobbies (crafts, music, dancing, reading ect): \_\_\_\_\_

Social activity with friends, family: \_\_\_\_\_ Church, charity, spiritual or inspiration activities: \_\_\_\_\_

Quiet, non-productive or relaxing time: \_\_\_\_\_ Average number of hours of sleep **per night**: \_\_\_\_\_

9. Do you feel you are a person of worth at least on an equal basis with others?

☐Very Much      ☐Much      ☐Somewhat      ☐A Little      ☐No

10. How much enjoyment or pleasure are you currently getting out of living?

☐Very Much      ☐Much      ☐Somewhat      ☐A Little      ☐No

11. What is your income range?

☐ Under \$20,000      ☐ \$20,000 - \$39,000      ☐ \$40,000 - \$59,000      ☐ \$60,000 - \$80,000      ☐ Over \$80,000

12. Please rate (from 1-10) how well you feel you are currently functioning in each of the three areas listed below

1-----2-----3-----4-----5-----6-----7-----8-----9-----10

Barely Able to Function | Severe Difficulty | Moderate Difficulty | Mild Difficulty | Well Functioning | Excellent Functioning

1) General Mood (Depression, anxiety, etc.): \_\_\_\_\_

2) Social Relationships: \_\_\_\_\_

3) Daily work or school: \_\_\_\_\_

### 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 Check	List Family Member
Alcohol/ Substance Abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Anxiety	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
ADHD	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Bipolar Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Domestic Violence	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Eating Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Learning Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Obesity	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Obsessive Compulsive Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Schizophrenia	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Sexual Abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Suicide Attempts	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____