Intake Form

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

Name:

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

Birth date: Age: Gender:

Relationship Status - Married/Single/Other?:

Please list any children/age:

Address:

Phone Number(s): May I leave a voice message? Text?

E-mail:

*Please note: neither E-mail nor text correspondence are considered confidential methods of communication. As such it is recommended that they are only used for scheduling information.

General Health and Mental Health Information

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

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:

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

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:

3. How many times a week to you generally exercise:

What types of exercise do you participate in?

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

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

Describe symptoms and time period:

6. Are you currently or have you ever experienced suicidal thoughts?

If yes, when did you begin experiencing this?

7. Have you ever attempted suicide?

If yes, what would you like me to know about this?

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

Describe symptoms and time period:

9. Are you currently experiencing chronic pain?

10. How often and in what amount do you drink alcohol?

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

12. Are you, or others, concerned about your alcohol or substance use?

If yes, please describe:

13. Are you currently in a romantic relationship?

14. Please list any type of mental health services you've received previously?

15. Current prescription medication:

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 (father, grandmother, uncle, etc.).

Alcohol/Substance Abuse:

Anxiety:

Depression:

Domestic Violence:

Eating Disorders:

Obsessive Compulsive Behavior:

Schizophrenia:

Suicidal Behavior:

Additional Information:

1. What is your current employment situation?

2. Do you consider yourself to be spiritual or religious?

3. What do you consider to be some of your strengths?

4. What do you consider to be some of your challenges?

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