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Intake Form

Please answer the following questions to the best of your knowledge/ability.
Please note: all information provided is protected as confidential information

Name:_____ Social Security Number:_____

Gender: □ Male □ Female Date of Birth:_____

Marital Status: □ Never married □ Domestic Partnership □ Married
□ Separated □ Divorced □ Widowed

Address: _____
(street & number) (city) (state) (zip)

May I mail to you at this address? □Yes □No, please send mail to _____

Home Phone: (____)_____ Work Phone: (____)_____

Cell Phone: (____)_____ May I text you at this number? □Yes □No

Note: Texting and phone calls will only be reserved for logistical issues, such as confirmation or cancellation of appointments. It will not be used for "phone sessions".

May I contact you and leave messages at any of these numbers? □Yes □No
If no, please contact me via _____

Email: _____ May I email you? □Yes □No
*please note: email correspondence is not considered to be a confidential medium of communication

Children (names and ages): _____

GENERAL HEALTH & MENTAL HEALTH INFORMATION:

Chief Concern

Please describe the main difficulty that has brought you to see me:

Your medical care (From whom or where do you get your medical care?)

Clinic name:

Phone:

Doctor's name:

Address:

If you enter treatment with me for psychological problems, may I tell your medical doctor so that he or she can be fully informed and we can coordinate your treatment? Yes No

Your current employer

Employer:

Work phone:

Address:

Occupation:

Length of time with this employer:

Please indicate any restrictions on calls:

Present relationships

How do you get along with your spouse or partner?

How do you get along with your children?

Past Psychological/Psychiatric Treatment

Have you ever received psychological, psychiatric, drug or alcohol treatment, or counseling services? Yes No

Please indicate which type of treatment (circle one): Inpatient Outpatient Both

If yes, please indicate:

When:

From Whom:

For What:

Results:

Have you ever taken medications for psychiatric or emotional problems? Yes No

If yes, please indicate:

When

From Whom:

For What:

Results:

List of Symptoms

Please circle any of the following that have been bothering you lately:

abused as child	agoraphobia	alcohol use
ambition	anger	anxiety
appetite	being a parent	bowel trouble
career choices	children	compulsions

compulsivity	concentration	confidence
depression	divorce	drug use/abuse
eating problem	education	energy (hi/low)
extreme fatigue	fears	fetishes
finances	friends	guilt
headaches	health problems	inferiority feelings
insomnia	loneliness	making decisions
marriage	memory	my thoughts
nervousness	nightmares	obsessive thinking
overweight	painful thoughts	panic attacks
phobias	relationships	sadness
self-esteem	separation	sexual problems
short temper	shyness	sleep
stress	suicidal thoughts	work

Please indicate how the issue(s) for which you are seeking treatment are affecting the following areas of your life:

Marriage / Relationship:

1 - No effect 2 – Little effect 3 – Some effect

4 – Much effect 5 – Significant effect Not Applicable

Family:

1 - No effect 2 – Little effect 3 – Some effect

4 – Much effect 5 – Significant effect Not Applicable

Job/school performance:

1 - No effect 2 – Little effect 3 – Some effect

4 – Much effect 5 – Significant effect Not Applicable

Friendships:

1 - No effect 2 – Little effect 3 – Some effect

4 – Much effect 5 – Significant effect Not Applicable

Financial situation:

1 - No effect 2 – Little effect 3 – Some effect

4 – Much effect 5 – Significant effect Not Applicable

Physical health:

1 - No effect 2 – Little effect 3 – Some effect

4 – Much effect 5 – Significant effect Not Applicable

Anxiety level / nerves:

1 - No effect 2 – Little effect 3 – Some effect

4 – Much effect 5 – Significant effect Not Applicable

Mood:

1 - No effect 2 – Little effect 3 – Some effect

4 – Much effect 5 – Significant effect Not Applicable

Eating habits:

1 - No effect 2 – Little effect 3 – Some effect

4 – Much effect 5 – Significant effect Not Applicable

Sleeping habits:

1 - No effect 2 – Little effect 3 – Some effect

4 – Much effect 5 – Significant effect Not Applicable

Sexual functioning:
1 - No effect 2 – Little effect 3 – Some effect

4 – Much effect 5 – Significant effect Not Applicable

Alcohol / drug use:

1 - No effect 2 – Little effect 3 – Some effect

4 – Much effect 5 – Significant effect Not Applicable

Ability to concentrate:

1 - No effect 2 – Little effect 3 – Some effect

4 – Much effect 5 – Significant effect Not Applicable

Ability to control anger:

1 - No effect 2 – Little effect 3 – Some effect

4 – Much effect 5 – Significant effect Not Applicable

Substance Use

Do you currently consume alcohol? Yes No

If yes, on average how many drinks per occasion do you consume?

How many days per week do you consume alcohol?

Do you have a history of problematic use of alcohol? Yes No

Have family members or friends expressed concern about your drinking? Yes No

Do you currently use non-prescribed drugs or street drugs? Yes No

Do you have a history of problematic use of prescription or non-prescription drugs?
Yes No

Do you have a family history of alcohol or drug problems? Yes No

If yes, please describe:

FAMILY MENTAL HEALTH HISTORY:

In this section below please 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	Family member
Alcohol/Substance Abuse	Yes / No	_____
Anxiety	Yes / No	_____
Depression	Yes / No	_____
Domestic Violence	Yes / No	_____
Eating Disorder	Yes / No	_____
Obesity	Yes / No	_____
Obsessive Compulsive Behavior	Yes / No	_____
Schizophrenia	Yes / No	_____
Suicide Attempts/Completion	Yes / No	_____

Family of Origin

Mother □alive □deceased (date: _____) Father □alive □deceased (date:_____)

Siblings (age and gender):

_____

_____

How would you characterize or describe the relationships with your family of origin (i.e., with your parents, with your siblings)?

Other

Is there anything else that is important for me as your therapist to know about and that you have not written about on any of these forms? Please tell me here; use the back of the paper if needed.