INTAKE FORM

Please provide the following information and answer the questions below. If any of the questions are difficult for you to answer or you would rather not answer, please know that you are welcomed to leave them blank. 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)

• Birth Date: ______ /______ /______ Age: ________

• Address:

____

(Street and Number)

____

(City) (State) (Zip)

• Home Phone:_____________________ May I leave a message? ▫ Yes ▫ No

Cell Phone:_______________________ May I leave a message? ▫ Yes ▫ No

E-mail: __________________________ May I email you? ▫ Yes ▫ No (Please note:Email correspondence is not considered to be a confidential medium of communication).

* Emergency Contact:
  * Name and Relation:____________________________________
  * Phone #: ____

With Whom Do You Live?
* ____

• Referred by (if any):

____

• Relationship Status:
□ Single, Never Married
□ Domestic Partnership
□ Married
□ Separated
□ Divorced
□ Widowed
□ partnered, not living together
□ polyamorous/non-monogamous
□ decline to answer

* I describe my ethnic/racial identity as: _____________________________

* My Current Gender Identity Is: ______________________

* My Sex Assigned at birth is: ________________________

* My Pronouns are: ________________________________

* My Sexual Orientation Is: __________________________

• Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?
□ Yes □ No

* Previous therapist/practitioner:

Name(s)____

• Are you currently taking any prescription medication?
▫ Yes ▫ No
Please list:
____

____

• Have you ever been prescribed psychiatric medication?
▫ Yes ▫ No
Please list and provide dates:

____

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

4. Are you currently experiencing overwhelming sadness, grief, or depression?
▫ Yes ▫ No
If yes, for approximately how long?

5. Are you currently experiencing anxiety, panic attacks, or have any phobias?
   ▫ Yes ▫ No
   If yes, when did you begin experiencing this?

6. Are you currently experiencing any chronic pain?
▫ Yes ▫ No
   If yes, please describe:

7. Do you have any history of substance (including alcohol) use?   Yes   No
   If Yes, please describe:

8. Do you currently engage in any substance use?   ▫ Yes   ▫ No
   If Yes, please describe:

9. Have you ever experienced life events that you consider traumatic? The event could have happened to you personally or you might have witnessed such events to someone else.
   ▫ Yes   ▫ No

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

<u>FAMILY HISTORY/FAMILY MENTAL HEALTH HISTORY:</u>

Family-of-origin history: In the section below, identify if there is a family Mental Health History (Ex: Depression, Bipolar Disorder, Anxiety, Obsessive Compulsive Behaviors, Eating Disorders, Schizophrenia, Suicide Attempts, Domestic Violence, etc.) Please list any other relevant known family mental heath history.

Relattionships	Name	Current Age (or age at death)	Mental Health History

ADDITIONAL INFORMATION:

1. Are you currently employed?
   ▫ Yes ▫ No

If yes, what is your current employment situation? (full-time, part-time, volunteer, etc.)

2. Are you currently in school?
   ▫ Yes ▫ No
   If yes, please list school names and your major:

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

4. Do you have any hobbies you enjoy?

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

▫ Yes ▫ No

If yes, describe your faith or belief:

6. Anything that would be helpful for me to know?

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