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Intake Information

Please provide the following information and answer the questions below. Please fill out this form and bring it to your first session. Please note: Information you provide here is protected as confidential information.

GENERAL INFORMATION

Client's name: ____
(Last) (First) (Middle Initial)

Name of parent or legal guardian: (if under 18 years of age)

____
(Last) (First) (Middle Initial)

Client's Date of Birth: ____________________ Age: ___________ Gender: (circle) Male Female

Marital Status: (circle) Never Married Domestic Partnership Married

Separated Divorced Widowed

Please list any children/age: ____

Please list any other family members living in the same household: ________________________________

Please list other unrelated people living in the same household: ________________________________

Client's Address: ____

City: ___________________________________ State: _______________ Zip: _________________

Home Phone: ______________________________ May we leave a message? Yes ________ No ________

Cell Phone: ______________________________ May we leave a message? Yes ________ No ________

E-mail Address: ______________________________ May we email you? Yes ________ No ________

(Please note: E-mail correspondence is not considered to be a confidential medium of communication)

Emergency Contact Name: __________________________ Relationship to Client: ________________________

Home Phone: __________________________ Cell Phone: ________________________

Referred by: (if any) ____

TREATMENTS & MEDICATIONS

Have you/your child previously received any type of mental health services (psychotherapy, psychiatric, etc.)?

Yes ________ No ________, Previous therapist/practitioner: ____

Are you/your child currently taking any prescription medications? Yes ________ No _______ If yes, please list:

Medication Name: ____ How long? _____________________

Medication Name: ____ How long? _____________________

Have you/your child ever been prescribed psychiatric medication? Yes ________ No ________

If yes, please list and provide dates:

Medication Name: ______________________________________ Dates: ________________ to ________________

Medication Name: ______________________________________ Dates: ________________ to ________________

HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate you/your child's current physical health? (circle)

   Poor Unsatisfactory Satisfactory Good Very Good

   Please list any specific health problems you/your child are currently experiencing:

   ____

   ____

   ____

2. How would you rate your/your child's current sleeping habits? (circle)

   Poor Unsatisfactory Satisfactory Good Very Good

   Please list any specific sleeping habit problems you/your child are currently experiencing:

   ____

3. How many times per week do you/your child generally exercise? ______________

   What types of exercise do you/your child participate in?

   ____

4. Please list any difficulties you experience with your/your child's appetite or eating patterns:

   ____

5. Are you/your child currently experiencing overwhelming sadness, grief or depression? Yes ______ No ______

   If yes, approximately how long? ____

6. Are you/your child currently experiencing anxiety, panic attacks or have any phobias? Yes ______ No ______

   If yes, when did you/your child begin experiencing this? ____

7. Are you/your child currently experiencing any chronic pain? Yes ______ No ______

   If yes, please describe: ____

8. Have you/your child ever been a victim of physical abuse? Yes ______ No ______

9. Have you/your child ever been a victim of sexual abuse? Yes ______ No ______

10. Have you/your child ever experienced significant trauma? Yes ______ No ______

ADDITIONAL INFORMATION

1. Are you/your child currently employed? Yes ______ No ______

   If yes, what is your/your child's current employment situation? ______________________________________

   Do you/your child enjoy the employment? Yes ______ No ______

   Is there anything stressful about you/your child's current work? ______________________________________

2. Do you/your child consider yourself to be spiritual or religious? Yes ______ No ______

3. What do you consider to be some of your/your child's strengths? ____________________________________

   ____

4. What do you consider to be some of your/your child's weaknesses? __________________________________

   ____

5. What would you like to accomplish during your/your child's time in therapy? __________________________

   ____

6. Do you/your child drink alcohol? Yes ______ No ______

   If so, is it more than once a week? Yes ______ No ______

7. How often do you/your child engage in recreational drug use? (circle)

   Daily Weekly Monthly Infrequently Never

8. Are you/your child currently in a romantic relationship? Yes ______ No ______

   On a scale of 1-10, how would you rate your/your child's relationship? ______________

9. What significant life changes or stressful events have you/your child experienced recently? _______________

   ____

10. Did you/your child achieve development tasks on target? Yes ______ No ______

    If no, please describe: ____

FAMILY MENTAL HEALTH HISTORY

In this section, 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 (ex. Father, Grandmother, Uncle, etc.)

			Family Member
Alcohol/Substance Abuse	Yes ______	No ______	______________________________
Anxiety	Yes ______	No ______	______________________________
Depression	Yes ______	No ______	______________________________
Domestic Violence	Yes ______	No ______	______________________________
Eating Disorders	Yes ______	No ______	______________________________
Obesity	Yes ______	No ______	______________________________
Obsessive Compulsive Behavior	Yes ______	No ______	______________________________
Schizophrenia	Yes ______	No ______	______________________________
Suicide Attempts	Yes ______	No ______	______________________________