

# INTAKE FORM

Please provide the following information and answer the questions below. 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)

Name of parent/guardian (if under 18 years):  
\_\_\_\_\_  
(Last) (First) (Middle Initial)

Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Gender:  Male  Female

Marital Status:  
 Never Married  Domestic Partnership  Married  Separated  
 Divorced  Widowed

Please list any children/age: \_\_\_\_\_

Address: \_\_\_\_\_  
(Street and Number)  
\_\_\_\_\_  
(City) (State) (Zip)

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

Cell/Other Phone: (\_\_\_\_) \_\_\_\_\_ May we leave a message?  Yes  No

E-mail: \_\_\_\_\_ 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, etc.)?

No  
 Yes, previous therapist/practitioner: \_\_\_\_\_

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: \_\_\_\_\_

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## 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:

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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:

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3. How many times per week do you generally exercise? \_\_\_\_\_

What types of exercise do you participate in: \_\_\_\_\_

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

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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 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:

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**Have you ever experienced:**

Extreme depressed mood	yes / no
Wild mood swings	yes / no
Rapid speech	yes / no
Extreme anxiety	yes / no
Panic attacks	yes / no
Phobias	yes / no
Sleep disturbances	yes / no
Hallucinations	yes / no
Unexplained losses of time	yes / no
Unexplained memory lapses	yes / no
Alcohol/substance abuse	yes / no
Frequent body complaints	yes / no
Eating disorder	yes / no
Body image problems	yes / no
Repetitive thoughts (eg, obsessions)	yes / no
Repetitive behaviors (eg, frequent checking, hand washing)	yes / no



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

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

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

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I HAVE READ AND UNDERSTAND THE HIPAA PRIVACY GUIDELINES:

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date