Intake Form

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

Date:_____

Client Name _____
First Middle Last
Address: _____
Street City State Zip
Home Phone: _____ Cell Phone: _____
May we leave a message: _____ May we leave a message: _____

Birthdate: _____ Age: _____ Gender: _____

Marital Status:
( ) Never married ( ) Domestic partner ( ) Married ( ) Separated
( ) Divorced ( ) Widowed

Name of Parent/Guardian (if under 18 years):
Relation: _____ Name _____
First MI Last
Address_____
Street City State Zip
Phone: _____ Cell phone: _____
May we leave a message: _____ May we leave a message: _____

Email: _____ May we email you: _____
**Please note: Email correspondence is not considered to be a confidential medium of communication.

Emergency contact: _____
_____

How did you hear about us? _____
Have you previously received any type of mental health services (psychotherapy, psychiatric services, in or out patient basis, etc.)? If so when, what and where.
_____
_____
_____
Are you currently taking any prescription (medical or psychiatric) medication?
_____
_____

CLIENT'S GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health?
   Poor Unsatisfactory Satisfactory Good Very Good
   Please list specifics: _____
   _____

2. How would you rate your current sleeping habits?
   Poor Unsatisfactory Satisfactory Good Very Good
   Please list specifics: _____
   _____

3. How many times per week do you generally exercise? _____
   What type of exercise? _____

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

5. Are you currently experiencing overwhelming sadness, grief or depression? ( ) Yes ( ) No
   If yes, for how long? _____

6. Are you currently experiencing anxiety, panic attacks or have any phobias? ( ) Yes ( ) No
   If yes, for how long? _____

7. Are you currently experiencing any chronic pain? ( ) Yes ( ) No
   If yes, please describe: _____
   _____

8. Do you drink alcohol more than once a week? ( ) Yes ( ) No
   If yes, how much and how often: _____

9. Do you currently engage in recreational drug use? ( ) Yes ( ) No
   If yes, list what, how much and for how long: _____
   _____

10. Are you currently in a romantic relationship? ( ) Yes ( ) No
    If yes how long? _____ Please rate on a scale of 1-10, with 10 highest: _____

11. What significant life changes or events have you experienced recently?
    _____
    _____
    _____
    _____

12. Do you have any substance abuse history? If so, what and when? Any treatment?
    _____
    _____
    _____
    _____
13. Have you experienced any type of trauma?
    _____
    _____
    _____
    _____
14. Do you have an history of suicidal ideation or attempts and/or homicidal ideation/attempts? If so, which and when?
    _____
    _____
15. Have you had any legal charges/convictions now or in the past? This is not held against you, it merely helps to understand your individual situation.
    _____
    _____
    _____
    _____
16. How many close friends do you have? _____
17. How close are you with your biological or surrogate family? Who are they?
    _____
    _____
    _____

FAMILY GENERAL HEALTH AND MENTAL HEALTH INFORMATION

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 in the space provided (father, mother, grandmother, uncle etc.)

	Please circle	List 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	

ADDITIONAL INFORMATION:

1. Are you currently employed? ( ) Yes ( ) No
   If yes, what is your current employment and position? _____
   Do you enjoy your work? Is there anything stressful about your current work?
   _____
   _____
   _____

2. Do you consider yourself to be spiritual or religious? ( ) Yes ( ) No
   If yes, describe: _____

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

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

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

Name of person completing the form: _____

Signature: _____