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:		
(First)	(Middle Initial)	
years):		
(First)	(Middle Initial)	
Age: Gende	er: Male Female	
stic Partnership □ Mar	rried Separated	
vorced Widowed		
(Street and Number)		
(State)	(Zip)	
(State) May we leave a	_	
` ,	a message? □Yes □No	
	(First) Age: Genderstic Partnership worced Widowed	

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:
1 louise 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:
r lease list any specific sleep problems you are currently experiencing.
3. How many times per week do you generally exercise?
What types of exercise to you participate in:
That types of energies to you purificipate in.

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

FAMILY MENTAL HEALTH HISTORY:

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, 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	r yes/no	
Schizophrenia	yes/no	
Suicide Attempts	yes/no	
If yes, what is your current emp	loyment situation	1:
Do you enjoy your work? Is the	ere anything stres	ssful about your current work?
2. Do you consider yourself to I	-	igious? □ No □ Yes

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?	