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# INTAKE FORM

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

Name: _____
(Last) (First) (Middle Initial)

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

Birth Date: _____ /_____ /_____

Marital Status:
□ Never Married □ Domestic Partnership □ Married □ Separated □ Divorced □ Widowed

Please list any children/age: _____

Address: _____
(Street and Number)

_____
(City) (State) (Zip)

Home Phone: ( ) Cell/Other Phone: ( )

May we leave a message at either of these numbers? □ Yes □ No

E-mail: _____

May we email you? □ Yes □ No

***Please note: Email correspondence is not considered to be a confidential medium of communication.***

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Insurance_____

Insured Name_____ Insured Date of Birth_____

ID number_____ Insured Employer_____

Group Number_____ Insurance Phone Number_____

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: _____
_____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

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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. How many times per week do you generally exercise? _____

What types of exercise to you participate 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? _____

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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? _____

FAMILY MENTAL HEALTH HISTORY:

In the section below, identify if there is a family history of any of the following. If yes, check the box and then please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

| | | |
|---|---|---|
| Alcohol/Substance Abuse | □ | _____ |
| Anxiety | □ | _____ |
| Depression | □ | _____ |
| Domestic Violence | □ | _____ |
| Eating Disorders | □ | _____ |
| Obesity | □ | _____ |
| Obsessive Compulsive Behavior | □ | _____ |

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| | | |
|---|---|---|
| Schizophrenia | □ | _____ |
| Bipolar Disorder | □ | _____ |
| Suicide Attempts | □ | _____ |

ADDITIONAL INFORMATION:

1. Are you currently employed? □ No □ Yes

If yes, what is your current employment situation?

_____

2. Do you consider yourself to be spiritual or religious? □ No □ Yes

If yes, describe your faith or belief:

_____

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

_____

_____

_____

_____

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

_____

_____

_____

_____