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INTAKE FORM

Please provide the following information to the extent you are comfortable. Note: information you provide here is protected as confidential information.

Name: ____ ________________________
First, Middle Initial, Last Today's Date

Name of parent/guardian (if under 18 years):

____ ________________________
First, Middle Initial, Last Today's Date

Birth Date: ______ /______ /______ Age: ________ Gender: ______________________________

Address: ____

Referred by (if any): ____

May I leave a message for the person referring you? □Yes □No

May I leave phone messages for you? □Yes □No

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

May I email you? □No □Yes E-mail address: ______________________________
(Please note: Email correspondence cannot be guaranteed to be confidential)

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

Children/ages: ____

____

Do you have current or past psychotherapists, psychiatrists or spiritual directors? □ No □ Yes

Current therapist/director & dates: ____

Past therapists/directors & dates: ____

____

____

(OVER)

Are you currently taking any prescription medications? □ No □ Yes. Please list with doses:

____

____

Have you ever been prescribed psychiatric medication? □ Yes □ No

Please list with doses and dates: _______________________________

____

GENERAL HEALTH INFORMATION

1. Please rate current physical health?

□ Poor □ Unsatisfactory □ Satisfactory □ Good □ Very good

Please list any specific health problems you are currently experiencing:

____

2. Please 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 exercise? ____________________________

What types 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? □ No □ Yes

If yes, for approximately how long?_______________________________

Have you ever felt suicidal or attempted suicidal? If yes, how many times? ______________

____

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 Please describe?

____

____

8. Amount and frequency of alcohol per week: ______________________________

9. Recreational drug use: □ Daily □ Weekly □ Monthly □ Infrequently □ Never.

Drugs of choice: ____

10. Are you currently in a romantic relationship? □ No □ Yes For how long?

____

On a scale of 1-10, how would you rate your relationship? __________________

11. Please list any significant life changes or stressful events you have experienced recently:

____

____

____

____

12. What have been some important turning points in your life?

____

____

____

____

13. What are you passionate about? _____________________________________

____

____

14. What brings you joy and wonder?____________________________________

____

____

____

15. What artistic, music, sports or other interests do you enjoy? ______________________________

____

16. What, if any, spiritual or religious interest and/or commitments do you have?____________________

____

____

FAMILY MENTAL HEALTH HISTORY

Please identify any family history of the following, indicating the family member's relationship to you (father, grandmother, uncle, etc.).

Alcohol/Substance Abuse: ____

Anxiety Depression: ____

Domestic Violence: ____

Eating Disorders: ____

Obesity: ____

Obsessive Compulsive Behavior:____

Schizophrenia: ____

Suicide Attempts: ____

ADDITIONAL INFORMATION

1. Are you currently employed? □ No □ Yes What is your current employment situation?

____

Do you enjoy your work? ____

Is there anything stressful about your current work?_____________________________________

____

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

____

____

(OVER)

3. In what areas do you feel less strong or more vulnerable?

4. What would you like to accomplish in our work together?

5. • If I were having a really good day, I would be doing the following:

• Life would no longer be worth living if I was not able to:

• Life would no longer be worth living if I had to:

6. Is there anything more you would like me to know? (Please use reverse side if necessary)

(OVER)