INTAKE FORM

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

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

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

Birth Date: _____/_____/_____ Age: _____ Gender: _____

Relationship Status (select all that apply):
☐ Never Married ☐ Long-Term Relationship ☐ Living with Partner ☐ Married
☐ Separated ☐ Divorced ☐ Widowed ☐ Casual Dating ☐ Single

Please list any children and their age:

_____

Address: _____
(Street Number) (Street Name) (Apt. #)

_____
(City) (State) (Zip)

Primary Phone Number: _____
May we call you at this number? ☐ Yes ☐ No
May we leave a voicemail at this number? ☐ Yes ☐ No
May we text you at this number? ☐ Yes ☐ No

Email: _____
May we email you at this email address regarding your own therapy with us?
☐ Yes ☐ No
*Please note: Texts and emails are not considered to be a confidential medium of communication.

How did you hear about us? _____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.?)
☐ No
☐ Yes, previous therapist/practitioner/doctor:

_____

Are you currently taking any prescription medication for therapeutic purposes or with mental health side effects?
☐ Yes ☐ No
If yes, please list:
_____
_____

Have you ever been prescribed psychiatric medication?
☐ Yes ☐ No
If yes, 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?

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 do you participate in? _____

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

_____

5. On a scale of 1-10, how positive, close and supportive are your relationships with your family? (please circle one)

1 2 3 4 5 6 7 8 9 10

On a scale of 1-10 positive, close, and supportive are your relationships with your friends? (please circle one)

1 2 3 4 5 6 7 8 9 10

6. Are you currently in a romantic relationship? ☐ Yes ☐ No
If yes, for how long? _____
If yes, on a scale of 1-10, how would you rate your relationship? _____

7. Are you currently experiencing overwhelming sadness, grief, or depression?
☐ Yes ☐ No
If yes, for approximately how long? _____

8. Are you experiencing anxiety, panic attacks or do you have any phobias?
☐ Yes ☐ No
If yes, when did you begin experiencing this? _____

9. Have you ever attempted suicide? ☐ Yes ☐ No
If yes, when? _____
Have you ever had consistent thoughts of not wanting to be alive? ☐ Yes ☐ No
If yes, how long ago? _____
Have you recently had thoughts of not wanting to be alive? ☐ Yes ☐ No
Have you ever had thoughts of killing yourself? ☐ Yes ☐ No
If yes, when? _____
Have you recently had thoughts of killing yourself? ☐ Yes ☐ No

10. Are you currently experiencing any chronic pain?

☐ Yes ☐ No
If yes, please describe: _____

11. Do you drink alcohol more than twice a week? ☐ Yes ☐ No

12. How often do you engage recreational drug use? ☐ Daily ☐ Weekly ☐ Monthly ☐ Infrequently ☐ Never

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.)

	(Pease 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	
Important Other: _____		

Additional Information:

1. Are you currently employed? ☐ Yes ☑ No
If yes, what is your current employment situation:

_____
Do you enjoy your work? Is there anything stressful about your current work?
_____
_____

2. Is your spirituality or religion a significant part of your life? ☐ Yes ☐ No

If yes, do you anticipate your spirituality or religion being a part of your work towards greater mental and relational health? ☐ Yes ☐ No

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

_____
_____
_____

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

_____
_____
_____

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

_____
_____
_____
_____
_____
_____