# INTAKE FORM

Please provide the following information for our records. Leave blank any questions you would rather not answer. Information you provide here is held to the same standards or confidentiality as our therapy.

Please fill out this form and bring it to your first session or allow yourself 30 minutes prior to your appointment to complete the form in the office.

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## CLIENT INFORMATION

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

Street Address:

_____
(Street and Number)

_____
(City) (State) (Zip Code)

Home Phone: ( ) Cell/work Phone: ( )

I give my permission to be called at: Home Yes/No Cell/work Yes/No

Special Instructions: _____, I understand that if I have caller ID, the therapist name may be disclosed to others. Please Initial _____

Email: _____ May we email you? Yes No
*Please be aware that email may not be confidential.

Birth Date: ____/____/____ Age: _____ Gender: Male Female

Marital Status: Never Married Partnered Married Separated Divorced Widowed

Number of Children: _____ Ages: _____

Referred by: _____

(Fill out this section if client is a minor)

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## MINOR CLIENT

Name of parent/guardian:

(Last) (First) (Middle Initial)

Parents are: (circle) Married Separated Divorced In process of divorce
Never Married

In the event of parents' separation and/or divorce, the court has set the following custody stipulations:
Physical Custody: (circle) mother/ father full shared other
Legal Custody: (circle) mother/father full shared other
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Current reason for seeking therapy:

Have you had pervious psychotherapy? Yes No

Previous therapist's name_____

Are you currently taking prescribed psychiatric medication (antidepressants or others)?
Yes No if yes, please list: _____

HEALTH AND SOCIAL INFORMATION

1. How is your physical health at present? (circle)
Poor Unsatisfactory Satisfactory Good Very Good

2. Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.):

3. Are you having any problems with your sleep habits? Yes No
If yes, check where applicable: Sleeping too little Sleeping too much
Poor quality of sleep Disturbing dreams Other _____

4. How many times per week do you exercise? _____
Approximately how long each time? _____

5. Are you having any difficulty with appetite or eating habits? Yes No
If yes, check where applicable: Eating less Eating more Bingeing

Restricting

Have you experienced significant weight change in the last 2 months? Yes No

6. Do you regularly use alcohol? Yes No

In a typical month, how often do you have 4 or more drinks in a 24-hour period?

7. How often do you engage in recreational drug use? Daily Weekly Monthly Rarely N/A

8. Have you had suicidal thoughts recently? Frequently Sometimes Rarely Never

Have you had suicidal thoughts in the past? Frequently Sometimes Rarely Never

9. Are you currently in a romantic relationship? Yes No

If yes, how long have you been in the relationship? _____

On a scale of 1-10, how would you rate the quality of your current relationship?__

Do you currently feel safe in this relationship? Yes No

10. In the last year, have you experience any significant life changes or stressors?

Have you ever experienced?

| | | | |
|---|---|---|---|
| Extreme depressed mood | yes/no | Wild mood swings | yes/no |
| Rapid speech | yes/no | Extreme anxiety | yes/no |
| Panic attacks | yes/no | Phobias | yes/no |
| Sleep disturbances | yes/no | Hallucinations | yes/no |
| Unexpected loss of time | yes/no | Unexplained memory lapses | yes/no |
| Alcohol/substance abuse | yes/no | Frequent Body Complaints | yes/no |
| Eating disorders | yes/no | Body Image Problems | yes/no |
| Repetitive thoughts (e.g., obsessions) | | | yes/no |
| Repetitive behaviors (e.g., frequent checking, hand-washing) | | | yes/no |
| Homicidal thoughts | yes/no | | |
| Suicide attempt | yes/no | | |

OCCUPATIONAL INFORMATION:

Are you currently employed? Yes No

If yes, who is your current employer/position? _____

If yes, are you happy in your current position? _____

Please list any work-related stressors, if any:_____

RELIGIOUS/SPIRITUAL INFORMATION:
Do you consider yourself to be religious? Yes No

If yes, what is your faith? _____

If no, do you consider yourself to be spiritual? Yes No

SEXUAL HEALTH HISTORY:
Are any of your current concerns related to your sexuality? Yes No

If yes, what are your concerns? _____

Do you have any current/past experiences with sexual abuse or trauma? Yes No

FAMILY MENTAL HEALTH HISTORY:
Has anyone in your family (either immediate family member or relative) experienced difficulty with the following?
(Circle any/all that apply and list family member, e.g. Sibling, Parent, Uncle, Aunt, grandparents. Etc,):

| Difficulty | | Family Member |
|---|---|---|
| Depression | yes/no | |
| Bipolar disorders | yes/no | |
| Anxiety disorders | yes/no | |
| Panic attacks | yes/no | |
| Schizophrenia | yes/no | |
| Alcohol/substance abuse | yes/no | |
| Eating disorders | yes/no | |
| Learning disabilities | yes/no | |
| Trauma history | yes/no | |
| Suicide attempts | yes/no | |

OTHER INFORMATION:

What do you consider to be your strengths?

What do you like most about yourself?

What are effective coping strategies that you've learned?

What are your goals for therapy?

Is there anything else that you would like me to know about you?