

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 you first session.

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

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

(Last) (First) (Middle Initial)

Address: _____
(Street and Number)

(City) (State) (Zip)

Home Phone: (_____) _____ **May we leave a voice message?** Yes No
May we leave a text message? Yes No

Cell / Other Phone: (_____) _____ **May we leave a voice message?** Yes No
May we leave a text message? Yes No

Email: _____ **May we email you?** Yes No

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

Safety Issues:
 None
 Suicidal Ideation
 Homicidal Ideation
 Other: _____

Background Information

Identification

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

Ethnicity:

- Asian Americans
- Black and African Americans
- Hispanic or Latino origin
- Middle Easterners and North Africans
- Native Americans and Alaskan Natives
- Native Hawaiians and other Pacific Islanders
- White Americans
- Two or more races

Religion:

- Buddhism
- Christianity
- Chinese tradition religion
- Hinduism
- Islam
- Jewish
- Nonreligions (Secular/Agnostic/Atheist) Primal-indigenous

Marital Status:

- Never Married
- Domestic Partnership
- Married
- Separated
- Divorced
- Widowed

Please list any children / age: _____

Referred by: (if any): _____

History of Present Problem

1. Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

- No
- Yes, previous therapist / practitioner: _____

Please describe your current symptoms, onset, duration, frequency, etc.:

Past Psychiatric History

Please describe any prior treatment, symptoms, diagnoses, hospitalization, suicide attempts, etc.:

1. Have you ever been prescribed psychiatric medication?

No

Yes

If yes, please list and provide dates: _____

Trauma History

Please describe if you have experienced any trauma, when it occurred, persons involved etc.:

Family Psychiatric History

Please describe any history of mental illness in the family, diagnoses, etc.:

Medical Conditions & History

Please describe your current and past medical conditions, treatments, allergies, etc.:

Current Medications

Please list any current medications, dosage, purpose, prescribing physician:

Substance Use

1. Do you drink alcohol more than once a week?
 - No
 - Yes

2. How often do you engage recreational drug use?
 - Daily
 - Weekly
 - Monthly

Please describe any substances, state date, last use, amount, frequency, etc.:

Family History

Please describe your family of origin, relationship with parents, siblings, significant other(s):

In this 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(s)
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	

Social History

1. 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? _____

2. What significant life changes or stressful events have you experienced recently:

3. Do you consider yourself to be spiritual or religious?

- No
- Yes

If yes, describe your faith or belief: _____

Please describe any significant relationships, social support, nature / quality of relationships, etc.:

Developmental History

Please describe any developmental milestones, delays, etc.:

Educational / Occupational History

1. Are you currently employed?

- No
- Yes

If yes, what is your current employment situation: _____

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

Please describe your level of education current, etc.:

Legal History

Please describe any arrest history, sentencing, DUI occurrences, incarceration, litigation, etc.:

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:

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. 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, please describe: _____

7. Are you currently experiencing any chronic pain?

No

Yes

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

9. What do you consider to be some of your weakness? _____

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