

# I N T A K E F O R M

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

*Please print 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.*

Name: \_\_\_\_\_  
(Last) (First) (Middle Initial)

Name of parent/guardian (if you are a minor):

\_\_\_\_\_  
(Last) (First) (Middle Initial)

Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Gender:  Male  Female

Marital Status:

Never Married  Partnered  Married  Separated  Divorced  Widowed Number of Children: \_\_\_\_\_

Local Address: \_\_\_\_\_  
(Street and Number)

\_\_\_\_\_  
(City) (State) (Zip)

Home Phone: ( ) - May we leave a msg?  Yes  No

Cell/Other Phone: ( ) - May we leave a msg?  Yes  No

E-mail: \_\_\_\_\_ May we email you?  Yes  No

\*Please be aware that email might not be confidential.

Referred by: \_\_\_\_\_

Are you currently receiving psychiatric services, professional counseling or psychotherapy elsewhere?  Yes  No

Have you had previous psychotherapy?

- No  
 Yes, Previous therapist's name \_\_\_\_\_

Are you currently taking prescribed psychiatric medication (antidepressants or others)?

- Yes  
 No

If Yes, please list: \_\_\_\_\_

If no, have you been previously prescribed psychiatric medication? \_\_\_\_\_

- Yes  No

If Yes, please list: \_\_\_\_\_

### HEALTH AND SOCIAL INFORMATION

1. How is your physical health at present? (please 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?  No  Yes If

yes, check where applicable:

Sleeping too little  Sleeping too much     Poor quality 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?  No  Yes

If yes, check where applicable:  Eating less  Eating more  Binging

Restricting

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

6. Do you regularly use alcohol?  No  Yes

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

Daily  Weekly  Monthly  Rarely  Never

7. How often do you engage recreational drug use?

Daily  Weekly  Monthly  Rarely  Never

8. Have you had suicidal thoughts recently?

Frequently  Sometimes  Rarely  Never

Have you had them in the past?

Frequently  Sometimes  Rarely  Never

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

If yes, how long have you been in this relationship? \_\_\_\_\_

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

10. In the last year, have you experienced 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
Unexplained losses of time	yes/no
Unexplained memory lapses	yes/no
Alcohol/Substance Abuse	yes/no
Frequent Body Complaints	yes/no
Eating Disorder	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?  No  Yes

If yes, who is your current employer/position?

If yes, are you happy at your current position? \_\_\_\_\_

Please list any work-related stressors, if any: \_\_\_\_\_

**RELIGIOUS/SPIRITUAL INFORMATION:**

Do you consider yourself to be religious?  No  Yes

If yes, what is your faith? \_\_\_\_\_

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

FAMILY MENTAL HEALTH HISTORY:

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (circle any that apply and list family member, e.g., Sibling, Parent, Uncle, etc.):

<u>Difficulty</u>	<u>Family Member</u>
-------------------	----------------------

Depression	yes/no
------------	--------

Bipolar Disorder	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?