INTAKE FORM

Please print and bring this completed form to your first appointment.
Please share only as much information as you feel comfortable sharing and note that any information you provide is protected as confidential information.

Last Name: First Name: Middle Initial:

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

Gender:

- ◯ Female
- ◯ Male
- ◯ Non-binary/ third gender

Relationship Status:

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

Please list any children and include their age(s):

Street Address:

City: State: Zip:

Primary Phone: May we leave a message? ◯ Yes ◯ No

Other Phone: May we leave a message? ◯ Yes ◯ No

Email Address: May we email you?* ◯ Yes ◯ No

**Please note that email correspondence is not considered a confidential means of communication.*

Referred by (if any):

GENERAL HEALTH INFORMATION

Have you received any type of mental health services in the past?

◯ Yes ◯ No

If yes, who was your previous therapist/practitioner?

Are you currently taking any prescription medication?

◯ Yes ◯ No

If yes, please list and provide the approximate date you began taking them:

Have you ever been prescribed psychiatric medication other than in your list above?

◯ Yes ◯ No

If yes, please list and provide the approximate dates for the period in which you took them:

How would you rate your current physical health?

◯ Excellent ◯ Very Good ◯ Good ◯ Fair ◯ Poor

Have you recently experienced any specific problems with your physical health?

◯ Yes ◯ No

If yes, please list any specific problems with your physical health

How would you rate your current sleeping habits?

◯ Excellent ◯ Very Good ◯ Good ◯ Fair ◯ Poor

Have you recently experienced any specific sleep problems?

◯ Yes ◯ No

If yes, please list any specific sleep problems:

How many times per week do you generally exercise?

◯ Not at all ◯ 1-2 times ◯ 3-4 times ◯ 5-7 times

In what types of exercise do you participate?

Do you have any difficulties with your appetite or eating patterns?

◯ Yes ◯ No

If yes, please list any difficulties with your appetite or eating patterns:

Are you currently experiencing overwhelming sadness, grief or depression?

◯ Yes ◯ No

If yes, for approximately how long?

Are you currently experiencing anxiety, panic attacks or have any phobias?

◯ Yes ◯ No

If yes, when did you begin experiencing this?

Are you currently experiencing any chronic pain?

◯ Yes ◯ No

If yes, please describe:

Are you currently in a romantic relationship?

◯ Yes ◯ No

If yes, for how long?

How would you rate your relationship?

◯ Excellent ◯ Very Good ◯ Good ◯ Fair ◯ Poor

Have you recently experienced any significant life changes or stressful events?

◯ Yes ◯ No

If yes, please describe:

FAMILY HEALTH HISTORY

In the section below, please identify if a member of your family has a history of any of the following.
Please check all that apply.

Anxiety

☐ Mother ☐ Father ☐ Sibling ☐ Grandparent
☐ Other _____

Alcohol/Substance Abuse

☐ Mother ☐ Father ☐ Sibling ☐ Grandparent
☐ Other _____

Depression

☐ Mother ☐ Father ☐ Sibling ☐ Grandparent
☐ Other _____

Domestic Violence

☐ Mother ☐ Father ☐ Sibling ☐ Grandparent
☐ Other _____

Eating Disorders

☐ Father ☐ Mother ☐ Sibling ☐ Grandparent
☐ Other _____

Internet/Gaming Addiction

☐ Mother ☐ Father ☐ Sibling ☐ Grandparent
☐ Other _____

Obesity

☐ Mother ☐ Father ☐ Sibling ☐ Grandparent
☐ Other _____

Obsessive Compulsive Behavior

☐ Mother ☐ Father ☐ Sibling ☐ Grandparent
☐ Other _____

Schizophrenia

☐ Father ☐ Mother ☐ Sibling ☐ Grandparent
☐ Other _____

Suicide Attempts

☐ Mother ☐ Father ☐ Sibling ☐ Grandparent
☐ Other _____

ADDITIONAL INFORMATION

Are you currently employed? ◯ Yes ◯ No

If yes, what is your employment situation?

Do you enjoy your work? ◯ Yes ◯ No

Is there anything stressful about your current job? ◯ Yes ◯ No

If yes, please describe:

Is spirituality or religion important to you? ◯ Yes ◯ No

If yes, please briefly describe your faith or belief:

What do you consider to be some of your strengths?

What do you consider to be some of your weaknesses?

What goals do you have for your time in therapy?