# INTAKE FORM

# GENERAL INFORMATION

**Name**__________________________________________ **Date**____________ **Gender** ☐ M or ☐ F

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

_________________________________________________________________________

**Birth Date:** ________________ **Age:** _____________

**Address:** __________________________________________________________________

City ___________________________State________________ Zip _______________________

**Home Phone:** _________________________________ **May we leave a message?** ☐ Yes ☐ No

**Cell/Other Phone:** _____________________________ **May we leave a message?** ☐ Yes ☐ No

**E-mail:** __________________________________________ **May we email you?** ☐ Yes ☐ No

**Referred by (if any):** _________________________________________________________

# GENERAL HEALTH AND MENTAL HEALTH

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

- ☐ No
- ☐ Yes, previous therapist/practitioner: ____________________________________________

**Are you currently taking any prescription medication?**

- ☐ Yes
- ☐ No
- ☐ Please list: _________________________________________________________________

  _________________________________________________________________

**Have you ever been prescribed psychiatric medication?**

- ☐ Yes
- ☐ No
- ☐ Please list and provide dates: ___________________________________________________

**How would you rate your current physical health?**

- ☐ Poor
- ☐ Unsatisfactory
- ☐ Satisfactory
- ☐ Good
- ☐ Very good

**Please list any specific health problems you are currently experiencing:**

_________________________________________________________________________

**How would you rate your current sleeping habits?**

- ☐ Poor
- ☐ Unsatisfactory
- ☐ Satisfactory
- ☐ Good
- ☐ Very good

**Please list any specific sleep problems you are currently experiencing:**

_______________________________________________________________________________

**How many times per week do you generally exercise?**

**What types of exercise to you participate in** _____________________________________________

**Please list any difficulties you experience with your appetite or eating patterns**

_______________________________________________________________________________

**Are you currently experiencing overwhelming sadness, grief or depression?**

- ☐ No
- ☐ Yes

**If yes, for approximately how long?** ______________________

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

- ☐ No
- ☐ Yes

**If yes, when did you begin experiencing this?** _________________________

**Are you currently experiencing any chronic pain?**

- ☐ No
- ☐ Yes

**If yes, please describe** _________________________

**Are you presently having relationship concerns or issues?**

- ☐ No
- ☐ Yes

**If so how often do you have conflict you are not able to resolve?**

- ☐ Daily
- ☐ Weekly
- ☐ Monthly
- ☐ Infrequently
- ☐ Never

**If you had to describe your major symptoms for which you are seeking therapy, they would be:**

- ☐ Depression
- ☐ Anxiety
- ☐ General Sadness
- ☐ Mood Swings

- ☐ Obsessive Worries
- ☐ Panic Anxiety
- ☐ Times of Confusion
- ☐ Loss of Memory
- ☐ Drug Abuse
- ☐ Inattention/Hyperactivity
- ☐ Behavior Problems
- ☐ Relationships or Family Issues
- ☐ Other ________________________

**Please check the major stressor(s) that preceded or accompanied your symptoms:**

- ☐ Marital Issues
- ☐ Parent/Child Issues
- ☐ Job Issues
- ☐ Health Issues
- ☐ Trauma
- ☐ Increased Obligations/Responsibilities
- ☐ Significant Change
- ☐ Financial Issues
- ☐ Issues of the Past (guilt, abuse, family of origin)
- ☐ Other______________________________
- ☐ Difficult to identify

**My symptoms began ________** ( weeks or months) **ago and have been**

- ☐ increasing
- ☐ decreasing
- ☐ no change

**My three biggest worries in life at the present time are:**

1.________________________________________________________________________

2.________________________________________________________________________

3.________________________________________________________________________

**Please describe your goals for therapy:**

1.________________________________________________________________________

2.________________________________________________________________________

3.________________________________________________________________________

**Please briefly describe the following:**

What brings you to therapy? What are your behaviors you would like to see change?

__________________________________________________________________________________________

If you noticed a positive behavior change from attending therapy, what would you notice?

__________________________________________________________________________________________

**Please check all of the following that you have experienced and how often:**

- ☐ Increased Crying
- ☐ Sad Mood
- ☐ Lack of Motivation
- ☐ Poor Concentration
- ☐ Change in Sleep Pattern
- ☐ Appetite Changes
- ☐ Weight Changes
- ☐ Lack of Interest
- ☐ Decreased Self Esteem
- ☐ Hopeless/ Helpless Feeling
- ☐ Being Withdrawn
- ☐ Nightmares
- ☐ Rapid Heartbeat
- ☐ Increased Sweating
- ☐ Shortness of Breath
- ☐ General Anxiety
- ☐ Chest Discomfort
- ☐ Feeling Dizzy
- ☐ Chills or hot flashes
- ☐ Outburst of Anger
- ☐ Inattention
- ☐ Hyperactivity
- ☐ Impulsiveness
- ☐ Fear of going crazy
- ☐ Restlessness, keyed up, decreased concentration, irritability, muscle tension, decreased sleep
- ☐ Startled Response
- ☐ Feeling "High" with racing thoughts, increased speech, decreased sleep and increased activity or energy level
- ☐ Hypervigilance- excessive attention and focus on all internal and external stimuli
- ☐ Excessive behaviors such as shopping, gambling etc. Please list any others
  ________________________________
  ________________________________
- ☐ Obsessions/Compulsions- constant checking, washing, or counting type behaviors; unrelenting worries
- ☐ Hallucinations (hearing voices/music that no one else hears)
- ☐ Avoidance of anything associated with a trauma you experienced
- ☐ Post-Traumatic Stress Experiences Please List
  _________________________________
- ☐ Fear or anxiety of places or inescapable situation
- ☐ Social Phobia- persistent fear of social or performance situations where embarrassment may occur
- ☐ Specific Phobia-persistent fear of certain objects or situations. Please list:
  _______________________________
- ☐ Isolating self from all contact with others
- ☐ Amnesia
- ☐ Running Away
- ☐ Truancy
- ☐ Memory impairment with trouble organizing and sequencing
- ☐ Undue health worries with no adequate explanation
- ☐ Agitated- irritable (easily annoyed and provoked to anger)
- ☐ Suspicious /Delusions/Paranoia

**Please select any of the following that you have EVER experienced:**

- ☐ Behavioral Problems
- ☐ Self Mutilation (cutting etc.) (If so, when was last occurrence)
- ☐ Eating Issues (Under or Overeating, Binging and Purging)
- ☐ Sexual Issues (addiction, performance anxiety, pornography)
- ☐ Legal Issues
- ☐ Severe Trauma
- ☐ Suicidal Thoughts If yes, when did you last experience such thoughts?
  ____________________

# FAMILY HISTORY

**Describe Relationship with Father:**

______________________________________________________________________________

______________________________________________________________________________

**Describe Relationship with Mother:**

______________________________________________________________________________

______________________________________________________________________________

**Describe Relationship with siblings: (how many, where you are in birth order, your "role")**

______________________________________________________________________________

______________________________________________________________________________

**In general would you describe your childhood and family of origin as:**

- ☐ Pleasant
- ☐ Great
- ☐ Normal amount of fussing but generally good
- ☐ Abusive
- ☐ I have very little memory of my childhood
- ☐ I was mostly withdrawn from my family
- ☐ Dysfunctional

**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, mother, grandmother, uncle, etc.).**

- ☐ Alcohol/Substance Abuse
- ☐ Anxiety
- ☐ Depression
- ☐ Domestic Violence
- ☐ Eating Disorders
- ☐ Obesity
- ☐ Obsessive Compulsive Behavior
- ☐ Schizophrenia
- ☐ Suicide Attempts

**CURRENT FAMILY or RELATIONSHIP:**

**Are you married?** ☐ Yes ☐ No **If yes, how many years?** _____
**Are you divorced?** ☐ Yes ☐ No **If yes, how many years?** ______

**I presently live** ☐ with spouse ☐ alone ☐ with parents ☐ other_____________________

**My sexual orientation is** ☐ heterosexual ☐ homosexual ☐ other ____________________

**My current support system (including friends and family) is:**

☐ Good ☐ Fair ☐ Poor

**Please describe any current stress in your marriage/family:**

**Do you have children ?** ☐ Yes ☐ No **If yes, how many?** ______
**Have you ever had an abortion?** ☐ Yes ☐ No
**Have you ever had a miscarriage?** ☐ Yes ☐ No
**Do you suffer from infertility?** ☐ Yes ☐ No ☐ Do not know

# RELIGIOUS BELIEFS

**Do you consider yourself religious/spiritual?** ☐ Yes ☐ No ☐ Somewhat
**If so, what denomination/religion do you practice?** ________________________
**Is this the same as your family of origin?** ☐ Yes ☐ No
**Do you attend church**?

- ☐ Never
- ☐ Rarely
- ☐ Occasionally
- ☐ Once a month
- ☐ Nearly every week or more

# SCHOOL/CAREER

**What level of education did you complete?**

- ☐ Did not complete
- ☐ GED
- ☐ High School
- ☐ Certification Program
- ☐ Some College
- ☐ College Degree
- ☐ Masters Degree
- ☐ PhD. or higher

**Where are you currently employed?** ________________________________________

**Are you satisfied in your job?** ☐ Yes ☐ No ☐ Somewhat

**Please describe any issues you may be having with your job/career or school:**

______________________________________________________________________________________

______________________________________________________________________________________