INTAKE FORM (For ages 13-Adult)

Please note: The information you provide here is protected as confidential information. ***Please fill out this form and bring it to your first session.***

Name: _____

Emergency Contact Name:_____ **Phone**:_____

Name of Primary Care Doctor:_____ **Phone**:_____

Name of parents/guardians (if under 18 years): _____

Birth Date: _____ /_____ /_____ **Age**: _____ **Gender Identity:** _____

Assigned Sex: Preferred Pronouns: SexualOrientation:

Marital Status:

Please list any children/age: _____

Your Address: _____

(Street and Number) (City) (State) (Zip)

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

E-mail: _____ May we email you? Yes / No

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

How did you hear of me? (Psychology Today, Friend, Website, Flyer, Business card, Other-please describe)

_____

Have you previously received any type of mental health services? If so, Dates/names of 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: _____

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 to 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? Yes / No. If yes, for how long?

6. Are you currently experiencing anxiety, panic attacks or have any phobias? Yes / No

If yes, when did you begin experiencing this? _____

7. Are you currently experiencing any chronic pain? Yes / No

If yes, please describe _____

8. Do you drink alcohol more than once a week? Yes / No

9. How often do you engage recreational drug use? Daily /Weekly / Monthly / Infrequently / Never

10. Are you currently in a romantic relationship? Yes / No

If yes, for how long? _____

On a scale of 1-10, how would you rate your relationship? _____

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

12. Have you ever been hospitalized?

If yes, please explain:

13. Do you utilize any positive coping skills to manage when things are challenging?

If yes, please explain:

14. Do you have any coping skills that are unhealthy?

If yes, please explain:

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, grandmother, biological mother, uncle, etc.).

Please Circle	**List Family Member**
Alcohol/Substance Abuse yes/no	
Anxiety yes/no	
Depression yes/no	
Bipolar yes/no	
Domestic Violence yes/no	

Please Circle **List Family Member /or Self**

Eating Disorders yes/no

Obesity yes/no

Obsessive Compulsive Behavior yes/no

Schizophrenia yes/no

Suicide Attempts yes/no

ADDITIONAL INFORMATION

1. Are you currently employed?

No Yes

If yes, what is your current employment situation:

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

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

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

4. Do you have a support system of family and/or friends? If yes, who?

5. Please list any hobbies:

6. Do you attend school? Where? Any issues or concerns at school?

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