

INTAKE FORM

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**Please provide the following information and answer the questions below.
Information you provide here is protected as confidential information.
Please fill out this form and bring it to your 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 message? Yes No
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 medium of communication.

Birth Date: _____ / _____ / _____ Age: _____
Gender: Male Female Transgender

How were you referred for services?

A. Type of services you are seeking: Individual Family Parent-Child Couples
(If you are seeking Couples Counseling, please have each Partner complete one of these forms)

Please describe the main difficulty that has brought you to see me:

B. 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?

C. Children: (please note, if you are here for family or parent-child services please fill out the part of this form entitled, "For Families, Couples, and Parent-Child")

Name	Current Age	School	Grade	Any Concerns?
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D. Romantic Relationship Status:

- Never Married Domestic Partnership Married Separated
 Divorced Widowed

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? _____

(Note: if you are seeking couples counseling please fill out the part of this form entitled, "For Families, Couples, and Parent-Child")

E. Relationships in your family-of-origin: Please describe the following:

1. Your parents' relationship with each other:

2. Your relationship with each parent and with other adults in your family:

3. (a) If you were to choose three adjectives to describe your mother, as you were growing up, what would they be?

- (b) If you were to choose three adjectives to describe your father, as you were growing up, what would they be?

4. Your parents' physical health problems, chemical use, and mental or emotional difficulties:

5. Your relationship with your brothers and/or sisters, in the past and present:

6. How would you describe your childhood?

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

- No
- Yes, previous therapist/practitioner:

G. Are you currently taking any prescription medication?

- Yes
- No

Please list:

H. 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

3. Do you have any concerns about the quality of your sleep? (If yes, please describe) _____

(a) How many hours per night do you sleep?

4. How many times per week do you generally exercise? _____
What types of exercise to you participate in? _____

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

6. Are you currently experiencing overwhelming sadness, grief or depression?

No

Yes

If yes, for approximately how long? _____

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

No

Yes

If yes, when did you begin experiencing this? _____

8. Are you currently experiencing any chronic pain?

No

Yes

If yes, please describe? _____

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

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

Infrequently Never

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

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, uncle, etc.).

Please list family member:

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

ADDITIONAL INFORMATION:

1. Do you consider yourself to be spiritual or religious? No Yes

If yes, describe your faith or belief:

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

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

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

For Families, Couples, and Parent-Child Clients

Please answer the following additional questions:

I. Present relationships:

a. How well do you get along with your spouse or partner?

b. Write 3 descriptors for how your spouse/partner relates to you:

c. Write 3 descriptors for how you relate to your spouse/partner:

d. Level of commitment to relationship:

1 2 3 4 5

e. Level of distress in the relationship:

1 2 3 4 5

f. How do you get along with your children?

g. Write 3 descriptors for your **relationship** with your child:

h. Who are you able to share your personal problems with?
