I N T A K E   F O R M

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Please provide the following information and answer the questions below. Please note: 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)

Birth Date: ______ /______ /______ Age: ________ Gender: □ Male □ Female

Marital Status:
□ Never Married □ Domestic Partnership □ Married □ Separated

□ Divorced □ Widowed

Please list any children/age: ____

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.

Referred by (if any): ____

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:

Are the medications helping you?

Do you have drug allergies? Please list:

Have you ever been prescribed psychiatric medication?
□ Yes
□ No

Please list and provide dates:

Did these medications help?

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health?

If you have ever been treated for any of the following, please circle and use the space below for details:

high blood pressure, diabetes, seizures, headaches, heart disease,

pulmonary disease, renal disease, thyroid problems, peptic ulcer, HIV,

fibromyalgia, chronic pain, glaucoma, statin use

Do you have a regular physician?

Approximate date last seen

2. Do you have any problems with your sleep?

3. Do you exercise?

If so, how often?

4. Do you have, now or in the past problems with your appetite ?

PSYCHIATRIC HISTORY

5. Are you currently experiencing overwhelming sadness, grief,

or depression If so, for how long?

Are you experiencing any of the following (please circle):

loss of pleasure, loss of concentration, crying spells,

decreased motivation, Impatience or irritability, loss of productivity,

decreased libido, thoughts of death or suicide?

Have you ever attempted suicide?

Are you having problems with mood swings?

Do you have symptoms such as racing thoughts, irritability, decreased need for sleep, increased impulsivity, risk taking, or grandiosity?

If so, please describe

Are you experiencing any of the following (please circle):

unusual thoughts or suspicions, hearing voices, seeing things other

feeling you are being spied on or harassed?

If so please explain____

____

____

6. Are you troubled by (please circle): anxiety, panic attacks, palpitations, difficulty breathing, repetitious behaviors, or irrational fears?

If so please explain:

7. Do you have problems with maintaining your focus or with completing tasks? Do you have any history of violence or of arrest?

8. Do you use alcohol?

If so, how many drinks do you drink in the average week?

Have you ever had a drinking problem?

9. Do you use recreational drugs?

If so please tell me the specific

Are you or have you ever been concerned about your drug use?

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

If yes, for how long?
Are you comfortable with your sex life?

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

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

If yes, describe your faith or belief

____

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

____

____

____

____

____

____

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

____

____

____

____

5. What would you like to accomplish in today's appointment?