Intake Form

Please take your time in providing the following information. The questions are designed to help me begin to understand you so that our time together can be as productive as possible. All information provided is confidential.

Today's Date: _____

Client's Contact Information

Name (First): _____ (Last): _____

Date of Birth: _____ Age:_____

Ethnicity: _____ Gender: _____Sexual Orientation_____

Physical Address: _____

Mailing Address: _____

City: _____ Zip code:_____

Email Address: _____

Main Phone: _____

*Is it okay to leave a message identifying myself at this number?

(circle one) YES NO Cell Phone: _____

**Would you like to receive appointment reminders? (Circle one) TEXT / PHONE

Do you consent to use of text and email? (Please review service contract for limits of confidentiality and privacy) YES NO

Insurance Company: _____

ID Number (including initials):_____ Group No:_____

How did you hear about me? _____

Emergency Contact

***Please note, I will only contact this person in the event of an emergency and will always inform you if I do so.**

Name: _____

Phone Number: _____

Alternate Number: _____

About You

Reason for contacting me about starting therapy: _____

_____

_____

_____

When did your problem first start? Within the last:

- In the last 30 days
- In the last 6--12 mnths
- 2 years ago
- During adolescence
- During childhood

What areas of your life have been affected because of this problem? _____

_____

Are you currently experiencing overwhelming sadness, grief or depression? Yes No

If yes, for approximately how long? _____

Suicidal thoughts in the last 30 days? Yes No

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

If yes, when did you begin experiencing this? _____

Please describe any major losses or traumas you have experienced: _____

_____

Goals you want to accomplish in working together:

_____

_____

_____

Have you previously received any type of mental health services? Yes No

If yes, which of the following:

- Psychotherapy
- Medication
- Outpatient Hospitalizations
- Inpatient Hospitalization

If yes, please provide:

Name of Provider or Facility: _____

Location:_____

Dates of treatment and reason for treatment

_____

Family History

Currently in a significant romantic relationship? (circle one) YES NO

Significant prior relationship (Divorced, widowed, ect)? (circle one) YES NO

Number of children, names and ages (if applicable): _____

_____

Dependent adults living with you (if applicable): (circle one) YES NO

If yes, List relationship _____

Family Mental Health History? _____

Employment/ Education History

Job Title: _____ Current Employer:_____

Highest level of education or current grade: _____

Occupational or Educational concerns (if applicable):

_____

_____

Medical History

Primary Care Physician: _____

Date of most recent exam: _____

Current medications taken on a regular basis: _____

_____

Please list any current medical problems (thyroid, cancer etc): _____

_____

Please list any significant medical history (cancer, accidents, surgeries):

_____

How would you rate your current sleeping habits?

- Poor
- Unsatisfactory
- Satisfactory
- Good
- Very Good

If you are having problems, in which phase of sleep are you experiencing issues?

- Falling asleep
- Staying asleep
- Awakening early
- Sleep apnea
- Nightmares

Are you currently experiencing any chronic pain? No Yes

If yes, please describe: _____

_____

Substance Abuse History

Please list any current substance use (alcohol, cigarettes, marijuana, etc.):

_____

Frequency of use for above substances: (circle one) DAILY WEEKLY MONTHLY

Please list any prior substance use (alcohol, cigarettes, marijuana, etc.)

_____

Are you currently in a substance abuse program or support group? (circle one) YES NO

Have you previously been a member of a substance abuse program or support group? YES NO

OTHER HISTORY

Have you ever been arrested? (Circle one) YES NO

If yes, please describe charges and outcome: _____

Do you currently have an assigned probation office or social worker for any reason? YES NO

What do you see as your strengths? _____

_____

What are some of the ways you cope/manage stress: (i.e. exercise, drink alcohol, etc):

_____

What are some of your hobbies and interests? _____

_____

_____

Please list any other information not listed on this form that you feel is pertinent to my working with you: _____

_____

_____

_____