INTAKE FORM

Name:_____
(Last) (First) (Middle Initial)

Reason for today's visit: _____

_____

Relationship Status:

☐Never Married ☐Domestic Partnership ☐Married
☐Separated ☐Divorced ☐Widowed

Please list any children/age: _____

_____

Are you currently employed? ☐Yes ☐No
Do you enjoy your work? ☐Yes ☐No

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:
_____

_____

Have you ever been hospitalized for a psychological condition? ☐Yes ☐No
If yes, please list dates:_____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health?

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:

_____

Do you have any functional impairments related to injury or illness? □Yes □No

If yes, please list and describe:

_____

Are you currently experiencing any chronic pain? □Yes □No

If yes, please describe: _____

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 do you participate in? _____

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

_____

How often do you engage recreational drug use?

□Daily □Weekly □Monthly □Infrequently □Never

How often do you drink alcohol?

□Daily □Weekly □Monthly □Infrequently □Never

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

_____

_____

_____

FAMILY MENTAL HEALTH HISTORY:

If there is a family history of any of the following, please circle:

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

ADDITIONAL INFORMATION

What do you consider to be some of your strengths?

_____

_____

_____

What do you consider to be some of your weaknesses?

_____

_____

_____

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

_____

_____

_____