Intake Form

*Please provide the following information for my records. Leave blank any question you would rather not answer. Information you provide here is held to the same standards of confidentiality as our therapy. Please print out this form and bring it to your first session.*

Today’s Date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Last) (First) (MI)

Your Birth Date: \_\_\_\_\_ /\_\_\_\_\_ /\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_

I identify myself as: □ Male □ Female □ Transgender /Intersex □ \_\_\_\_\_\_\_\_\_\_\_\_

Sexual Preference: □ Men □ Women □ Both □ None □\_\_\_\_\_\_\_\_\_\_\_

Address:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Street and Number)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(City) (State) (Zip)

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ May I leave a message? □Yes □No

Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ May I leave a message? □Yes □No

E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ May I email you? □Yes □No

\*Please be aware that email might not be confidential.

Marital Status: □ Never Married □ Partnered □ Married □ Separated □ Divorced □ Widowed

Are you currently in a romantic relationship? □Yes □No Partners Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If yes, for how long?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If yes, on a scale of 1-10 (10=great), how would you rate the quality of your romantic relationship? \_\_\_\_\_\_

Do you have children? □No □Yes

If yes, how many?: \_\_\_\_\_ Ages: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

OCCUPATIONAL, FINANCIAL, EDUCATIONAL, & LEGAL INFORMATION:

Highest level of education:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you employed? □ No □ Yes

Current employer/position? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you happy at your current position? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have financial concerns? □ No □ Yes

If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently in the military? □ No □ Yes Previously? □ No □ Yes

Do you have any legal concerns? □ No □ Yes

If yes, please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HEALTH INFORMATION

How is your physical health currently? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Primary Care doctor:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Name) (Phone)

Please list any chronic health problems or concerns (e.g. asthma, hypertension, diabetes, headaches, stomach pain, seizures, etc.):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medications:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

LIFESTYLE QUESTIONS

Hours per night you normally sleep \_\_\_\_\_\_\_

Are you having any problems with your sleep habits? □ No □ Yes

If yes, check where applicable:

□ Sleeping too little □ Sleeping too much □ Can’t fall asleep □ Can’t stay asleep

Do you exercise regularly? □ No □ Yes

If yes, how many times per week do you exercise? \_\_\_\_\_\_ For how long? \_\_\_\_\_\_\_\_\_

If yes, what do you do?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you having any difficulty with appetite or eating habits? □ No □ Yes

If yes, check where applicable: □ Eating less □ Eating more □ Bingeing □ Purging

Have you experienced significant weight change in the last 2 months? □ No □ Yes

Do you regularly use alcohol? □ No □ Yes

If yes, what is your frequency?

□ once a month □ once a week □ daily □ daily, 3 or more □ intoxicated daily

How often do you engage in recreational drug use? □ Daily □ Weekly □ Monthly □ Rarely □ Never

List drugs you use?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you smoke cigarettes? □ No □ Yes

If yes, how many cigarettes per day?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you drink caffeinated drinks? □ No □ Yes

If yes, # of sodas per day\_\_\_\_\_\_ cups of coffee per day\_\_\_\_\_\_\_

Have you ever had a head injury? □ No □ Yes

If yes, when and what happened?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

INFORMATION:

What prompted you to seek therapy or an assessment at the current time?

What are your overall goals for therapy?

In the last year, have you experienced any significant life changes or stressors?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had previous psychotherapy? □No □Yes

If yes, please explain?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently taking prescribed psychiatric medications (antidepressants or others)? □Yes □No

If Yes, please list names and doses: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If No, have you been previously prescribed psychiatric medication? □Yes □No

Please list names and dates: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you hopeful about your future? □Yes □No

Are you having current suicidal thoughts? □ Frequently □ Sometimes □ Rarely □ Never

If yes, have you recently done anything to hurt yourself? □Yes □No

Have you had suicidal thoughts in the past? □ Frequently □ Sometimes □ Rarely □ Never

If you checked any box other than “never”, when did you have these

thoughts?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did you ever act on them? □Yes □No

Are you having current homicidal thoughts (i.e., thoughts of hurting someone else)? □Yes □No

Have you previously had homicidal thoughts? □Yes □No

If yes, when?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you **currently** experiencing: Rating Scale 1-10 (10 =worst)

*Only rate the areas to which you say “yes”*

Depressed Mood or Sadness yes no \_\_\_\_\_\_

Irritability/Anger yes no \_\_\_\_\_\_

Mood Swings yes no \_\_\_\_\_\_

Rapid Speech yes no \_\_\_\_\_\_

Racing Thoughts yes no \_\_\_\_\_\_

Anxiety yes no \_\_\_\_\_\_

Constant Worry yes no \_\_\_\_\_\_

Panic Attacks yes no \_\_\_\_\_\_

Phobias yes no \_\_\_\_\_\_

Sleep Disturbances yes no \_\_\_\_\_\_

Hallucinations yes no \_\_\_\_\_\_

Paranoia yes no \_\_\_\_\_\_

Poor Concentration yes no \_\_\_\_\_\_

Alcohol/Substance Abuse yes no \_\_\_\_\_\_

Frequent Body Complaints ( e.g., headaches) yes no \_\_\_\_\_\_

Eating Disorder yes no \_\_\_\_\_\_

Body Image Problems yes no \_\_\_\_\_\_

Repetitive Thoughts (e.g., Obsessions) yes no \_\_\_\_\_\_

Repetitive Behaviors (e.g., counting ) yes no \_\_\_\_\_\_

Poor Impulse Control (e.g., ↑ spending) yes no \_\_\_\_\_\_

Self Mutilation yes no \_\_\_\_\_\_

Sexual Abuse yes no \_\_\_\_\_\_

Physical Abuse yes no \_\_\_\_\_\_

Emotional Abuse yes no \_\_\_\_\_\_

Have you experienced in the **past**: Rating Scale 1-10 (10 =worst)

*Only rate the areas to which you said “yes”*

Depressed Mood or Sadness yes no \_\_\_\_\_\_

Irritability/Anger yes no \_\_\_\_\_\_

Mood Swings yes no \_\_\_\_\_\_

Rapid Speech yes no \_\_\_\_\_\_

Racing Thoughts yes no \_\_\_\_\_\_

Anxiety yes no \_\_\_\_\_\_

Constant Worry yes no \_\_\_\_\_\_

Panic Attacks yes no \_\_\_\_\_\_

Phobias yes no \_\_\_\_\_\_

Sleep Disturbances yes no \_\_\_\_\_\_

Hallucinations yes no \_\_\_\_\_\_

Paranoia yes no \_\_\_\_\_\_

Poor Concentration yes no \_\_\_\_\_\_

Alcohol/Substance Abuse yes no \_\_\_\_\_\_

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Repetitive Thoughts (e.g., Obsessions) yes no \_\_\_\_\_\_

Repetitive Behaviors (e.g., counting ) yes no \_\_\_\_\_\_

Poor Impulse Control (e.g., ↑ spending) yes no \_\_\_\_\_\_

Self Mutilation yes no \_\_\_\_\_\_

Sexual Abuse yes no \_\_\_\_\_\_

Physical Abuse yes no \_\_\_\_\_\_

Emotional Abuse yes no \_\_\_\_\_\_

FAMILY HISTORY:

Are your parents: □ still together

□ divorced, when\_\_\_\_\_\_\_\_\_\_\_\_

□ remarried

□ unmarried

□ deceased, if yes whom\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ age at death\_\_\_\_\_\_

Number of siblings:\_\_\_\_\_\_\_ Ages:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have good family support? □ No □ Yes From whom?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FAMILY MENTAL HEALTH HISTORY:

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (circle any that apply and list family member, e.g., Sibling, Parent, Uncle, etc.):

Difficulty Family Member(s)

Depression yes/no \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Bipolar Disorder yes/no \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Anxiety Disorders yes/no \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Panic Attacks yes/no \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Schizophrenia yes/no \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Alcohol/Substance Abuse yes/no \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Eating Disorders yes/no \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Learning Disabilities yes/no \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Trauma History yes/no \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Suicide Attempts yes/no \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Psychiatric Hospitalizations yes/no \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

OTHER INFORMATION:

What role, if any, do religion and/or spirituality play in your life?

Are you satisfied with your social situation/interpersonal relationships? □ No □ Yes

If no, explain why:

What do you consider to be your strengths? What do you like most about yourself?

What are effective coping strategies you use when stressed?

Is there anything that I did not ask about here that would be important for me to know about you?

How did you learn about me?