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 OR send via email.* *drtdipaola@icloud.com**.*

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:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Length of time in current relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Cohabitating

□ Living together

□ Living apart

As you think about the primary reason that brings you here, how would you rate its frequency and your overall level of concern at this point in time?

Concern

□ No concern

□ Little concern

□ Moderate concern

□ Serious concern

□ Very serious concern

Frequency

□ No occurrence

□ Occurs rarely

□ Occurs sometimes

□ Occurs frequently

□ Occurs nearly always

What do you hope to accomplish through counseling?

What have you already done to deal with the difficulties?

What are your biggest strengths as a couple?

Please rate your current level of relationship happiness by circling the number that corresponds with your current feelings about the relationship.

1\_\_\_\_\_2 3 4 5 6 7 8 9 10

(extremely unhappy) (extremely happy)

Please make at least one suggestion as to something you could personally do to improve the relationship regardless of what your partner does.

Have you received prior couples counseling related to any of the above problems? □ Yes □ No

If yes, when: By whom:

Length of treatment:

Problems treated:

What was the outcome (check one)?

□ Very successful □ Somewhat successful □ Stayed the same □ Somewhat worse □ Much worse

Have either you or your partner been in individual counseling before? □Yes □ No

If so, give a brief summary of concerns that you addressed.

Do either you or your partner drink alcohol to intoxication or take drugs to intoxication?

□Yes □ No

If yes for either, who, how often and what drugs or alcohol?

Have either you or your partner struck, physically restrained, used violence against or injured the other person?

□Yes □ No

If yes for either, who, how often and what happened.

Has either of you threatened to separate or divorce (if married) as a result of the current relationship problems?

□Yes □ No

If married, have either you or your partner consulted with a lawyer about divorce?

Do you perceive that either you or your partner has withdrawn from the relationship?

□Yes □ No If yes, which of you has withdrawn?

How frequently have you had sexual relations during the last month?

How enjoyable is your sexual relationship? (Circle one)

1 2 3 4 5 6 7 8 9 10

(extremely unpleasant) (extremely pleasant)

How satisfied are you with the frequency of your sexual relations? (Circle one)

1 2 3 4 5 6 7 8 9 10

(extremely unsatisfied) (extremely satisfied)

What is your current level of stress (overall)? (Circle one)

1 2 3 4 5 6 7 8 9 10

(no stress) (high stress)

What is your current level of stress (in the relationship)? (Circle one)

1 2 3 4 5 6 7 8 9 10

(no stress) (high stress)

Rank order the top three concerns that you have in your relationship with your partner (1 being the most problematic):

I.

2.

3.

Lastly, please draw a graph indicating your level of relationship satisfaction beginning with when you met your partner. Note pivotal/significant events in your relationship (e.g., one of you moved out, one of you cheated).

Relationship over time

Complete satisfaction

When you met/began dating Current

No satisfaction

Thank you for completing this. Please bring this with you during your first appointment. Please note that you will be asked to talk about your answers in sessions but your partner will not be shown this form.

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

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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?

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

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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:

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