INTAKE FORM

GENERAL INFORMATION

Name____________________________ **Date**____________ **Gender** M or F

Name of parent/guardian (if under 18 years):

____

Birth Date: ______ /______ /______ **Age:** _____________

Address: ____

____

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

Referred by (if any): ____

GENERAL HEALTH AND MENTAL HEALTH

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: ____

How would you rate your current physical health?

- Poor
- Unsatisfactory
- Satisfactory
- Good
- Very good

Please list any specific health problems you are currently experiencing:

____

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 to you participate in _________________________________

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

____

Are you currently experiencing overwhelming sadness, grief or depression?

- No
- Yes

If yes, for approximately how long? ________________________

Are you currently experiencing anxiety, panic attacks or have any phobias?

- No
- Yes

If yes, when did you begin experiencing this? ___________________________

Are you currently experiencing any chronic pain?

- No
- Yes

If yes, please describe ___________________________

Are you presently having relationship concerns or issues?

- No
- Yes

If so how often do you have conflict you are not able to resolve?

- Daily
- Weekly
- Monthly
- Infrequently
- Never

If you had to describe your major symptoms for which you are seeking therapy, they would be:

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o Depression

o Anxiety

o General Sadness

o Mood Swings

o Obsessive Worries

o Panic Anxiety

o Times of Confusion

o Loss of Memory

o Drug Abuse

o Inattention/Hyperactivity

o Behavior Problems

o Relationships or Family Issues

o Other _________________________

Please check the major stressor(s) that preceded or accompanied your symptoms:

o Marital Issues

o Parent/Child Issues

o Job Issues

o Health Issues

o Trauma

o Increased Obligations/Responsibilities

o Significant Change

o Financial Issues

o Issues of the Past (guilt, abuse, family of origin)

o Other_____________________________

o Difficult to identify

My symptoms began ________ (weeks or months) **ago and have been**

- o increasing
- o decreasing
- o no change

My three biggest worries in life at the present time are:

1.____

2.____

3.____

Please describe your goals for therapy:

1.____

2.____

3.____

Please briefly describe the following:
What brings you to therapy? What are your behaviors you would like to see change?

If you noticed a positive behavior change from attending therapy, what would you notice?

Please check all of the following that you have experienced and how often:

- Increased Crying
- Sad Mood
- Lack of Motivation
- Poor Concentration
- Change in Sleep Pattern
- Appetite Changes
- Weight Changes
- Lack of Interest
- Decreased Self Esteem
- Hopeless/ Helpless Feeling
- Being Withdrawn
- Nightmares
- Rapid Heartbeat
- Increased Sweating
- Shortness of Breath
- General Anxiety
- Chest Discomfort
- Feeling Dizzy
- Chills or hot flashes
- Outburst of Anger
- Restlessness, keyed up, decreased concentration, irritability, muscle tension, decreased sleep
- Startled Response
- Feeling “High” with racing thoughts, increased speech, decreased sleep and increased activity or energy level
- Hypervigilance- excessive attention and focus on all internal and external stimuli
- Excessive behaviors such as shopping, gambling etc. Please list any others___________________________
- Inattention
- Hyperactivity
- Impulsiveness
- Fear of going crazy
- Obsessions/Compulsions- constant checking, washing, or counting type behaviors; unrelenting worries
- Hallucinations (hearing voices/music that no one else hears)
- Avoidance of anything associated with a trauma you experienced
- Post-Traumatic Stress experiences Please List________________________________ ______________
- Fear or anxiety of places or inescapable situation
- Social Phobia- persistent fear of social or performance situations where embarrassment may occur
- Specific Phobia-persistent fear of certain objects or situations Please list_________________________________
- Isolating self from all contact with others
- Amnesia
- Running Away
- Truancy
- Memory impairment with trouble organizing and sequencing
- Undue health worries with no adequate explanation
- Agitated- irritable (easily annoyed and provoked to anger)
- Suspicious /Delusions/Paranoia

Please select any of the following that you have EVER experienced:

o Behavioral Problems

o Self Mutilation (cutting etc.) (If so, when was last occurrence)

o Eating Issues (Under or Overeating, Binging and Purging)

o Sexual Issues (addiction, performance anxiety, pornography)

o Legal Issues

o Severe Trauma

o Suicidal Thoughts If yes, when did you last experience such thoughts? ____________________

FAMILY HISTORY

Describe Relationship with Father:

Describe Relationship with Mother:

Describe Relationship with siblings: (how many, where you are in birth order, your "role")

In general would you describe your childhood and family of origin as:

o Pleasant

o Great

o Normal amount of fussing but generally good

o Abusive

o I have very little memory of my childhood

o I was mostly withdrawn from my family

o Dysfunctional

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, mother,

grandmother, uncle, etc.).

- 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

CURRENT FAMILY or RELATIONSHIP:

Are you married? Y/ N **If yes, how many years?_____ Are you divorced?** Y /N **How many years?** ____

I presently live ____ with spouse ____alone ____with parents ____ other____________________

My sexual orientation is _____heterosexual _____ homosexual _____other

My current support system (including friends and family) is:

____Good _____ Fair _____Poor

Please describe any current stress in your marriage/family:

Do you have children ? Y or N **If yes, how many?** ______ **Have you ever had an abortion?** _____

Have you ever had a miscarriage? ______ **Do you suffer from infertility?** Y or N or Do not know

RELIGIOUS BELIEFS

Do you consider yourself religious/spiritual? Y/N/Somewhat
If so, what denomination/religion do you practice?_________________________
Is this the same as your family of origin? Y/N
Do you attend church?

- Never
- Rarely
- Occasionally
- Once a month
- Nearly every week or more

SCHOOL/CAREER

What level of school did you complete?

- **Where are you currently employed?**____

Are you satisfied in your job? Y or N or Somewhat

Please describe any issues you may be having with your job/career or school:

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