# INTAKE FORM

Please provide the following information and answer the questions below.
**Please note:** Information you provide here is protected as confidential information. **Please fill out this form and bring it to your first session.**

**Name:**

______________________________________________________________________

Last) (First) (Middle Initial)

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

______________________________________________________________________

(Last) (First)

Birth Date: ______ /______ /______ Age: ________ Gender: _______

**Marital Status:**

▫ Never Married ▫ Married ▫ Separated ▫ Divorced

▫ Widowed On a scale of 1-10, how would you rate your relationship? __________

▫ Please list all people living in household:

*Name Relationship to Child Age*

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

**Address**:

______________________________________________________________________

______________________________________________________________________

(City) (State) (Zip)

Cell/Other Phone:
May I leave a message or a text?

E-mail:
May I email you? ▫ Yes ▫ No

***Please note: Email correspondence is not considered to be a confidential medium of communication.***

How did you find out about these services?

**Briefly describe your current difficulties:**

How long has this been a concern for you? ________________________________________________

When this problem was first noticed? _____________________________________________________

Have you previously received any type of mental health services (psychotherapy, psychiatric services?

▫ No ▫ Yes

Are you currently taking any prescription medication or psychiatric medication?

▫ No ▫ Yes. Please list.

Have you ever been prescribed psychiatric medication?

▫ No ▫ Yes

**GENERAL HEALTH AND MENTAL HEALTH INFORMATION**

1. How would you rate your current physical health? (please circle)
   Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:

2. How would you rate your current sleeping habits? (Please circle)
   Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:

3. How many times per week do you generally exercise? __________

What types of exercise to you participate in?

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

5. Are you currently experiencing overwhelming sadness, grief, or depression? ▫ No ▫ Yes
If yes, for approximately how long ______________________________________

6. Are you currently experiencing anxiety, panic attacks, or have any phobias?
▫ No ▫ Yes If yes, when did you begin experiencing this? ___________________________

7. Are you currently experiencing any chronic pain?
▫ No ▫ Yes
If yes, please describe:

8. Do you drink alcohol more than once a week? ▫ No ▫ Yes

9. How often do you engage recreational drug use?

▫ Daily ▫ Weekly ▫ Monthly ▫ Infrequently ▫ Never

10. Have you ever experienced physical abuse? ▫ No ▫ Yes
If yes, at what age?

11. Have you ever experienced sexual abuse? ▫ No ▫ Yes
If yes, at what age?

12. What significant life changes or stressful events have you experienced recently?

13: Have you ever had legal problems involving the court system or law enforcement? ▫ No ▫ Yes
If yes, Please explain

14. What is your highest degree of education completed? Please list date of completion and from what school.

15. Have you experienced the death of someone close to you? ▫ No ▫ Yes
If yes, please describe.

16. Have you ever been hospitalized for mental health concerns? ▫ No ▫ Yes
If yes, please explain with date and place.

**ADDITIONAL INFORMATION:**

**1.** Are you currently employed?
If yes, what is your current employment situation?

▫ No ▫ Yes

▫

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(Job Title)

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(Name of Employer) (Address)

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(City) (State) (Zip Code)

Do you enjoy your work? Is there anything stressful about your current work? ▫ No ▫ Yes

2. Do you consider yourself to be spiritual or religious? ▫ No ▫ Yes
If yes, describe your faith or belief:

3. What would you like to accomplish in this process?