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) (Middle Initial)

Birth Date: _____/_____/_____ Age: _____ Gender: _____

Marital Status:

_____Never Married _____Domestic Partnership _____ Married _____Separated

_____Divorced _____ Widowed

Please list children/ages: _____

_____

Address: _____

(Street and Number) (City) (Prov.) (Postal Code)

Home Phone: (_____)_____May we leave a message? _____Yes _____No

Cell/Other Phone (_____)_____ May we leave a message? _____Yes _____No

E-mail: _____ May we e-mail you? _____Yes _____No

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

Referred by (if any): _____

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?

_____ No

_____Yes, Please list: _____

_____

Have you ever been prescribed psychiatric medication?

_____ No

_____Yes, Please list: _____

_____

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? _____

   Whap types of exercise do you participate in? _____

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

5. Are you currently experiencing over whelming 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, once a week?

_____ No

_____ Yes, if yes how often? _____

9. How often do you engage in recreational drug us?

_____ Daily _____ Weekly _____ Monthly _____ Infrequently _____ Never

10. Are you currently in a romantic relationship?

_____ No

_____ Yes, If yes, for how long? _____

11. What significant life changes or stressful event have you experienced recently? _____

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, grandmother, uncle, etc).

	Please Circle	List Family Member
Alcohol/Substance Abuse	yes/no	
Anxiety	yes/no	
Depression	yes/no	
Domestic Violence	yes/no	
Eating Disorder	yes/no	
Obesity	yes/no	
Obsessive Compulsive Behavior	yes/no	
Schizophrenia	yes/no	
Suicide Attempts	yes/no	

ADDITIONIAL INFORMATON:

1. Do you have any goals you would like to obtain from your therapy sessions?

_____

2. Are you currently employed?

_____ No

_____ Yes, If yes, what is your current employment situation?

_____

Signature Date