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INTAKE FORM

PLEASE FILL IN THE INFORMATION BELOW AND BRING IT WITH YOU TO YOUR FIRST SESSION. PLEASE NOTE: INFORMATION PROVIDED ON THIS FORM IS PROTECTED AND CONFIDENTIAL INFORMATION.

Client Name:____Date:_____________________

Parent/Legal Guardian (if under 18): ____

Address: ____

Home Phone: ________________________________ May we leave a message? □ Yes □ No

Cell/Work/Other Phone: ______________________ May we leave a message? □ Yes □ No

Email: _____________________________________ May we leave a message? □ Yes □ No

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

DOB: _____________________________ Age: _______ Gender: ____________________________

Marital Status: □ Never Married □ Domestic Partnership □ Married □ Separated □ Divorced □ Widowed

Referred By (if any): ____

Emergency Contact Name:_________________________ Relationship: _______________________

Address:____ Phone: ____________________________

MENTAL HEALTH HISTORY AND CURRENT SYMPTOMS

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

□ No □ Yes, previous therapist/practitioner/clinic: ___________________________________

Are you currently taking any prescription medication?

□ No □ Yes, please list:

____

____

____

What brings you or your child into therapy at this time (what are your concerns)?

____
____
____
____

PATIENT HEALTH QUESTIONNAIRE 9 (PHQ 9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? (circle)

		Never	Several Days	More than half the days	Nearly everyday
1.	Little interest or pleasure in doing things	0	1	2	3
2.	Feeling down, depressed, or hopeless	0	1	2	3
3.	Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4.	Feeling tired or having little energy	0	1	2	3
5.	Poor appetite or overeating	0	1	2	3
6.	Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7.	Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8.	Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9.	Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

□ Not difficult at all □ Somewhat difficult □ Very difficult □ Extremely difficult

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.

GENERALIZED ANXIETY DISORDER 7-ITEM (GAD-7) SCALE

Over the last 2 weeks, how often have you been bothered by any of the following problems? (circle)

		Never	Several Days	More than half the days	Nearly everyday
1.	Feeling nervous, anxious or on edge	0	1	2	3
2.	Not being able to stop or control worrying	0	1	2	3
3.	Worrying too much about different things	0	1	2	3
4.	Trouble relaxing	0	1	2	3
5.	Being so restless that it's hard to sit still	0	1	2	3
6.	Becoming easily annoyed or irritable	0	1	2	3
7.	Feeling afraid as if something awful might happen	0	1	2	3

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

□ Not difficult at all □ Somewhat difficult □ Very difficult □ Extremely difficult

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. *Arch Inern Med.* 2006;166:1092-1097.

Are you currently in any physical pain (stomach aches, headaches, etc.)? □ Yes □ No

In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, in the past month, you:

1. Have had nightmares about it or thought about it when you did not want to? □ Yes □ No
2. Tried hard not to think about it or went out of your way to avoid situations that reminded you of it? □ Yes □ No
3. Were constantly on guard, watchful, or easily startled? □ Yes □ No
4. Felt numb or detached from others, activities, or your surroundings? □ Yes □ No