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INTAKE FORM

Client Name: _____

Primary Care Physician Name: _____

Primary Care Physician Address: _____

Current Medications: _____

Current medical conditions or significant Medical History: _____

_____

Have you ever been admitted to a psychiatric hospital? ____Yes ____ No If yes, please specify when and where? _____

Has anyone in your family ***(blood relatives)*** ever been diagnosed with a mental illness? ____Yes ____ No
If yes, please specify illness and relationship to patient.

_____

Has anyone in your family ever attempted suicide? ____Yes ____ No

What problems are you presently experiencing?
_____
_____
_____

How long have you been experiencing this problem?
_____

What do you expect from therapy?
_____
_____
_____

Have you ever, or are you now, being treated for any type of chemical dependency abuse? ____Yes ____ No
If yes, when? _____ Where? _____
Length of Treatment _____

Are you at the present time using any type of chemical substances? _____ Yes _____No If yes, please indicate what you are using (drugs and/or alcohol)._____

How frequently do you use these substances? _____

Please ***check ALL*** that apply to you:

___ Irritability
___ Insomnia
___ Drug Use
___ Sexual Problems
___ Sleep Related Problems
___ Eating Problems
___ Weight Gain
___ Weight Loss
___ Changes in appetite
___ Problems Relaxing
___ Work Problems
___ Problems with Thoughts
___Phobias
___Cutting/Self-harm
___Crying spells
___Alcohol Abuse

___Financial Problems
___Marital Problems
___Sexual Abuse /trauma
___Confused
___Feeling paranoid
___Helplessness
___Troubling thoughts
___Worrying
___Co-Dependency
___Loneliness
___Physical Abuse
___Emotional Abuse
___Domestic violence
___Panic attacks
___Suicidal thoughts

___Anger
___Sadness
___Confusion
___Depression
___Anxiety
___Guilt
___Grief
___Fear
___ Low Self-Esteem
___ Low Self-Confidence
___Impulsivity
___No pleasure
___Relationship difficulties
___No energy
___Trouble concentrating