Maximize Wellness
Counseling & Coaching

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THERAPY INTAKE FORM

Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information.

Name: ____Date: __________________

Address: ____

Phone: ______________________ May we leave a message at this number: Y N

Email:____ May we email you: Y N

(Please note that email correspondence is not considered to be a confidential medium of communication)

Date of birth: __________________ Age:____ Sex:_____ Marital status: __________________

Occupation: __________________________ Education: _______________________________

Please provide one emergency contact name and number:_______________________________

Please list any other members living in household – name, age, relationship:

____

____

How did you hear about this practice?____

Are you currently taking any prescription or OTC medications? Y N

If yes please list:____

Do you exercise regularly? Y N

What is the reason you are seeking therapy? ____

____

____

Current Symptoms (Check All That Apply)			
☐ Anxiety	☐ Appetite Issues	☐ Avoidance	☐ Crying Spells
☐ Depression	☐ Excessive Energy	☐ Fatigue	☐ Guilt
☐ Hallucinations	☐ Impulsivity	☐ Irritability	☐ Libido Changes
☐ Loss of Interest	☐ Panic Attacks	☐ Racing Thoughts	☐ Risky Activity
☐ Sleep Changes	☐ Suspiciousness	☐ Suicidal Thoughts	☐ Self Harm (cutting)

Please describe:____

____

Do you have a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided.

Alcohol/substance abuse	Y	N	____________________
Anxiety	Y	N	____________________
Depression	Y	N	____________________
Domestic Violence	Y	N	____________________
Eating Disorder	Y	N	____________________
Obesity	Y	N	____________________
Obsessive Compulsive Disorder	Y	N	____________________
Schizophrenia	Y	N	____________________
Suicide Attempts	Y	N	____________________

On a scale of 1 to 10 with ten being the highest, circle the number that represents how you would describe yourself.

	Not at all	**Somewhat**	**Above Averag**	**Agree**
I am optimistic.	1 2	3 4 5	6 7 8	9 10
I am satisfied with my life.	1 2	3 4 5	6 7 8	9 10
I am satisfied with my health.	1 2	3 4 5	6 7 8	9 10
I am satisfied with my financial situation.	1 2	3 4 5	6 7 8	9 10
I am satisfied with my social life.	1 2	3 4 5	6 7 8	9 10
I feel good about my personal relationships.	1 2	3 4 5	6 7 8	9 10

What are your three most significant accomplishments?

____

____

____

What are your three most significant disappointments?

____

____

____

Describe your top three strengths

____

____

____

Describe your most aggravating weakness ____
____

When are you the happiest? ____
____
____

When do you feel the lowest? ____
____

How would you describe your state of health and well-being? ____________________________
____
____

Who are your sources of support? Home/ Work/ School_________________________________
____
____

What are your goals / dreams? ____
____
____

What (if any) obstacles have prevented you from your goals? _____________________________
____
____

Anything Else You Want Maximize Wellness to Know

I certify the information I have provided is true and correct to the best of my knowledge.

Signed______________________________ Date________________________