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PATIENT INTAKE FORM

Information provided below will be a part of your records and is held to the same standards of confidentiality as what is discussed in therapy.

DEMOGRAPHIC INFORMATION

LEGAL NAME _____

PREFERRED NAME _____

ADDRESS _____
STREET APT #

_____
CITY STATE ZIP CODE

DATE OF BIRTH: _____ AGE _____

PHONE NUMBER: _____

RACE/ETHNICITY: _____

GENDER IDENTITY: Female ( ) Male ( ) Non-binary ( ) Gender Fluid ( )
Transgender M to F ( ) Transgender F to M ( ) Prefer not to answer ( ) Not listed ( )
Please specify _____

SEXUAL ORIENTATION: Straight ( ) Gay ( ) Lesbian ( ) Bisexual ( ) Not listed ( )
Please specify _____

PREFERRED PRONOUNS: She/her /hers ( ) He/him/his ( ) They/them/theirs ( )
Not listed ( ) Please specify _____

MARITAL STATUS: Single ( ) Married ( ) Separated ( ) Divorced ( ) Widowed ( )

CHILDREN : Yes ( ) No ( ) If yes, how many _____ Ages _____

INSURANCE INFORMATION

INSURANCE COMPANY:_____

INSURED PARTY:_____

RELATIONSHIP TO INSURED PARTY:_____

ID#:_____

VALID SINCE: _____

COPAYMENT: _____

TREATMENT HISTORY

Are you currently receiving psychiatric services, professional counseling or psychotherapy elsewhere? ( ) yes ( ) no

Have you had previous psychotherapy?
( ) no
( ) yes, with (previous therapist's name)_____

Are you currently taking prescribed psychiatric medication (antidepressants or others)? ( ) yes ( ) no

If yes, please list: _____

Prescribed by: _____

Have you ever been hospitalized for psychiatric reasons?' ( ) yes ( ) no

If yes, on how many occasions? _____ facility? _____

when? _____duration?_____reason_____

HEALTH AND SOCIAL INFORMATION

Do you currently have a primary physician? ( ) yes ( ) no

If yes, who is it? _____

Are you currently seeing more than one medical health specialist? ( ) yes ( ) no

If yes, please list: _____

When was your last physical? _____

Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.: _____

Are you currently on medication to manage a physical health concern? If yes, please list: _____

_____

Are you experiencing any disturbance of your normal sleeping patterns? ( ) yes ( ) no

If yes, check where applicable:

( ) Sleeping too little ( ) Sleeping too much ( ) Poor quality sleep

( ) Disturbing dreams ( ) other _____

How many times per week do you exercise? _____

Approximately how long each time? _____

Are you having any difficulty with appetite or eating habits? ( ) no ( ) yes

If yes, check where applicable: ( ) Eating less ( ) Eating more ( ) Bingeing ( ) Restricting

Have you experienced significant weight change in the last 2 months? ( ) no ( ) yes

Do you regularly use alcohol? ( ) no ( ) yes

In a typical month, how often do you have 4 or more drinks in a 24 hour period?

_____

How often do you engage recreational drug use? ( ) daily ( ) weekly ( ) monthly ( ) rarely ( ) never

If so, what is your drug of choice? _____

Do you smoke cigarettes or use other tobacco products? ( ) yes ( ) no

Have you had suicidal thoughts recently?
( ) frequently ( ) sometimes ( ) rarely ( ) never

Have you had them in the past?
( ) frequently ( ) sometimes ( ) rarely ( ) never

Are you currently in a romantic relationship? ( ) no ( ) yes

If yes, how long have you been in this relationship? _____

On a scale of 1-10 (10 being the highest quality), how would you rate your current relationship? _____

In the last year, have you experienced any significant life changes or stressors? If yes, please explain: _____

_____

Are you happy with your current level of social interactions? ( ) no ( ) yes

How often do you spend timeout with friends? _____

Are you happy with your familial relationships? ( ) no ( ) yes

Who are you closest to? _____

With whom do you currently reside? _____

Do you own ( ) or rent ( )?

Have you ever experienced any of the following?

Extreme depressed mood	Yes / No
Dramatic mood swings	Yes / No
Rapid speech	Yes / No
Extreme anxiety	Yes / No
Panic attacks	Yes / No
Phobias	Yes / No
Sleep disturbances	Yes / No
Hallucinations	Yes / No
Unexplained losses of time	Yes / No
Unexplained memory lapses	Yes / No
Alcohol/substance abuse	Yes / No
Frequent body complaints	Yes / No
Eating disorder	Yes / No
Body image problems	Yes / No
Repetitive thoughts (e.g. obsessions)	Yes / No
Repetitive behaviors (e.g. frequent checking, hand washing	Yes / No
Homicidal thoughts	Yes / No
Suicidal attempts	Yes / No If yes, when?

OCCUPATIONAL INFORMATION

Are you currently employed? ( ) no ( ) yes

Full time ( ) Part time ( ) Seasonal ( ) Temporary ( )

If yes, who is your currently employer/position? _____

If yes, are you happy with your current position? _____

Please list any work-related stressors, if any _____

_____

Are you currently enrolled in an educational or vocational program? ( ) no ( ) yes

If so, where and what are you studying? _____

_____

RELIGIOUS/SPIRITUAL INFORMATION

Do you consider yourself to be religious? ( ) no ( ) yes

If yes, what is your faith? _____

If no, do you consider yourself to be spiritual? ( ) no ( ) yes

FAMILY MENTAL HEALTH HISTORY

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (circle any that apply and list family member, e.g. sibling parent, uncle, etc. as well as whether there are related to you via your father (paternal) or your mother (maternal).

Difficulty	Yes / No	Family member	Paternal/ Maternal
Depression	Yes / No		P / M
Bipolar disorder	Yes / No		P / M
Anxiety disorder	Yes / No		P / M
Panic attacks	Yes / No		P / M
Schizophrenia	Yes / No		P / M
Alcohol/substance abuse	Yes / No		P / M
Eating disorders	Yes / No		P / M
Learning disabilities	Yes / No		P / M
Trauma history	Yes / No		P / M
Suicide attempts	Yes / No		P / M
Suicidal Thoughts	Yes / No		P / M
Chronic illness	Yes / No		P / M
Traumatic Brain Injury	Yes / No		P / M

ADDITIONAL INFORMATION

What do you consider to be your strengths? _____

_____

_____

What do you like most about yourself? _____

_____

What do you consider to be your areas of improvement?_____

_____

What do you dislike most about yourself? _____

_____

What are some effective coping strategies that you have learned? _____

_____

_____

What are some ineffective coping strategies that you have learned? _____

_____

_____

What are your goals for therapy?

_____

_____

_____

_____

_____

_____

_____

_____

What else would you like me to know about you or what beings you in to see me today?

_____