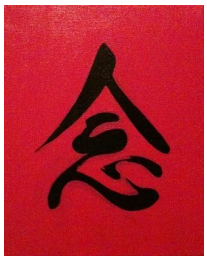

I N T A K E
F O R M

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

Name:

_____

(Last) (First) (Middle Initial)

Name of parent/guardian (if under 18 years):

_____
__

(Last) (First) (Middle Initial)

Birth Date: _____ /_____ /_____ Age: _____ Gender: ☐ Male ☐ Female
SS#_____

Marital Status:

☐ Never Married ☐ Domestic Partnership ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Please list any children & age(s):

_____

Address: _____

(Street and Number)

_____

(City) (State) (Zip)

Employer:_____

Home Phone: ( ) _____May we leave a message? ☐Yes ☐No

Cell/Other Phone: ( ) _____May we leave a message? ☐Yes ☐No

E-mail: _____May we email you? ☐Yes ☐No

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

Referred by (if any):_____

(May we thank the person that referred you?) ☐Yes ☐No

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?

☐ Yes

☐ No

Please list:
_____

_____
_

Have you ever been prescribed psychiatric medication?

☐ Yes

☐ No

Please list and provide dates:

_____

_____

_

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 including pain, gastrointestinal problems, cancer, heart issues, thyroid etc.:

_____

_

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?

_____

What types of exercise to you participate in:

_____

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

_____

_

5. Are you currently experiencing overwhelming 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 than once a week? ☐ No ☐ Yes

If yes, how often do you drink alcohol and how many drinks do you consume when you drink?_____

__

9. How often do you engage in recreational drug use? ☐ Daily ☐ Weekly ☐ Monthly ☐ Infrequently ☐ Never

10. Are you currently in a romantic relationship? ☐ No ☐ Yes

If yes, for how long?

_____

On a scale of 1-10, how would you rate your relationship? _____

11. What significant life changes or stressful events 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 and List Family Member:

Alcohol/Substance- Abuse yes/no

_____

Anxiety- yes/no

_____

Depression- yes/no

_____

Domestic Violence- yes/no

_____

Eating Disorders- yes/no

_____

Obesity-yes/no

_____

Obsessive Compulsive Behavior- yes/no

_____

Schizophrenia- yes/no

_____

Suicide Attempts- yes/no

_____

ADDITIONAL INFORMATION:

1. Are you currently employed? ☐ No ☐ Yes

If yes, what is your current employment situation:

_____

Do you enjoy your work? Is there anything stressful about your current work?

_____

_____

2. Do you consider yourself to be spiritual or religious? ☐ No ☐ Yes

If yes, describe your faith or belief:

_____

3. What do you consider to be some of your strengths?

_____

_____

_____

_____

4. What do you consider to be some of your weakness?

_____

_____

_____

_____

5. What would you like to accomplish with your time in therapy?

_____

_____

_____

_____