INTAKE FORM

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

Please fill out this form and bring it to your first session.

Name: ____

(Last) (First) (Middle Initial)

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

____

(Last) (First) (Middle Initial)

Birth Date: ______ /______ /______ Age: ______ Gender: □ Male □ Female

Marital Status:
□ Single, Never Married □ Engaged □ Domestic Partnership □ Separated
□ Married, first marriage
□ Married, second marriage
□ Married, third or more marriages
□ Divorced □ Widowed

Please list any children/age: ____

Address: ____

(Street and Number)

____

(City) (State) (Zip)

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): ______________________________

Inventory of Concerns

Identify if you have experienced any of the following in the past 3 weeks:

- □ Depressed Mood
- □ Hopelessness
- □ Suicidal Thoughts
- □ Disturbed Sleep
- □ Appetite Changes
- □ Significant Weight Loss
- □ Difficulty Concentrating
- □ Agitation
- □ Mood Swings
- □ Tension/Anxiety
- □ Significant Fear
- □ Hostility
- □ Family Problems
- □ Guilt
- □ Health Problems
- □ Marital Conflict
- □ Employment/School Related Difficulti
- □ Abuse (physical, verbal, sexual)
- □ Other: ______________________

Have you ever been sexually assaulted/abused? □ Yes □ No
Have you ever been physically assaulted/abused? □ Yes □ No

Social History

List immediate family members (include parents, siblings, children and other important people)

Family Member	Age	Relationship	Description of Relationship	Do they live with you? (Y/N)

*** Who may we call in an emergency? ______________________phone:___________

Describe any family history of alcoholism, drug use, depression, abuse, suicide, mental illness, or other significant difficulty.

Describe any medical problems you have (including allergies)

List any medications you currently take:

List and describe any past or present therapy or counseling in which you have been involved.

Alcohol Use: ☐ Never ☐ Less than 1 time/month ☐ 1-4 times per month
☐ ______ times per week ☐ Daily

Alcohol Consumption Per Sitting: ☐ None ☐ 1-2 drinks ☐ 3-4 drinks ☐ 5 drinks

Have you experienced any of the following related to alcohol use?
☐ Binges ☐ Job Problems ☐ Sleep Disturbances ☐ Physical Withdrawal ☐ Arrests
☐ Hangovers ☐ Blackouts ☐ Medical Complications ☐ Assaults ☐ Inability to stop
☐ Interpersonal Conflict with Relationships ☐ Concern about drinking

What other substances do you use, or have you used in the past 6 weeks? (check all that apply)

☐ Cigarettes ☐ Caffeine ☐ Marijuana ☐ Sedatives ☐ Hallucinogens

☐ Cocaine ☐ Opiates ☐ Inhalants ☐ Stimulants ☐ Prescription Drugs

Rank your current problem as you see it:

☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
1	2	3	4	5	6	7	8	9	10
Best Ever									Worst Ever

Where would you like the problem to be (i.e. when will you know when counseling is over?)

☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
1	2	3	4	5	6	7	8	9	10
Best Ever									Worst Ever

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health? (please circle)

Poor   Unsatisfactory   Satisfactory   Good   Very good

2. How many times per week do you generally exercise? ______________________

What types of exercise do you participate in: ______________________________

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? __________

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	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 weaknesses?

____

____

____

____

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

____

____

____

____

____

Please choose the phrase that best describes your motivation for today’s visit:

☐ I don’t have a problem;someone else thinks I do.
☐ I do have a problem; I do want to change, but at the same timed I don’t want to change.
☐ I am getting ready to change and am about to make the commitment.
☐ I have already begun taking action to resolve this problem.
☐ I have achieved my goal and focused on preventing relapse.
☐ I have relapsed and I am seeking to regain control.

Please circle any of the following that is a concern to you:

Nervousness	Depression	Fears	Shyness
Physical Abuse	Sexual Problems	Suicidal Thoughts	Separation
Divorce	Finances	Anger	Self-Control
Friends	Parenting	Sleep Problems	Stress
Work/School	Relaxation	BizarreThoughts	Headaches
Tiredness	Legal Problems	Memory	Stomach Problems
Ambition	Hyperactivity	Nightmares	Making Decisions
Gambling	Loneliness	Low Self-Esteem	Concentration
Education/grades	Binge Eating	Career	Relationships
Marriage	Health Problems	Temperament	Eating too little
Children	Defiant Behavior	Unhappiness	Sexual Abuse
Eating too much	Road Rage	Fighting	Perfectionism
Panic	Impulsiveness	Drugs/Alcohol Abuse	Lying
Obsessiveness			

It is highly recommended that you consider a medical evaluation with a physician or psychiatrist if you are struggling with depression, anxiety or other mental health issue that can be effectively treated with medication.

Signature of person completing information: ______________________ Date: _________