Intake Form

(All information on this form is strictly confidential)

Name: ____________________ **Gender:** ____________

Date of Birth: ____________________ **Age:** ____________

Home Address: ____________________ **Phone:** ____________

E-mail Address: ____________________

May your therapist contact you via (please select "yes" on at least one):

Phone call? ◻ Yes ◻ No
Text message? ◻ Yes ◻ No
E-mail? ◻ Yes ◻ No
Voicemail message? ◻ Yes ◻ No

Emergency Contact

Name: ____________________ **Relationship:** ____________________

Phone: ____________________

Primary Care Physician

Name: ____________________ **Phone:** ____________________

Medical History

Allergies: ____________________

Height: ____________________ **Current Weight:** ____________

List of current medications, dosage, and response/ side-effects (if any):

____

____

List of current medical problems (if any):

____

____

Reason for seeking therapy: ____________________

____

____
____
Briefly describe what you are seeking to get from therapy: ___________________________
____
____

Family History

Do you have any children? □ Yes □ No

Names of Children	**Living with you?**	**Age**
1. ________________________	□ Yes □ No	_____
2. ________________________	□ Yes □ No	_____
3. ________________________	□ Yes □ No	_____
4. ________________________	□ Yes □ No	_____
5. ________________________	□ Yes □ No	_____

Other than any children already indicated above, who lives in your household?
____
____
____
____

Please describe your relationships with other family members:

Relationship:	**Living?**	**Describe quality of relationship:**
Father	**□yes□no□n/a**	________________________________
Mother	**□yes□no□n/a**	________________________________
Step-father	**□yes□no□n/a**	________________________________
Step-mother	**□yes□no□n/a**	________________________________
Spouse/partner	**□yes□no□n/a**	________________________________
Sister(s)	**□yes□no□n/a**	________________________________
Brother(s)	**□yes□no□n/a**	________________________________
Other________	**□yes□no□n/a**	________________________________

Whom were you raised by? ____
Were you adopted? □ Yes □ No
If so, at what age? ____________________

What family member(s) were you closest to as a child?

____

____

What family members(s) are you closest to now?

____

____

Check the statement(s) below that describe the type of family you grew up in:

□ overly close family
□ little-to-no relationship
□ no privacy
□ boundaries not respected
□ not a lot of support
□ not much time spent together
□ boundaries respected
□ comfortably close family
□ supportive
□ loving
□ distant
□ shared many positive experiences
□ violence
□ verbal conflicts
□ angry, lots of fighting/hostility
□ abuse ___emotional ___physical ___sexual
□ other____

Please check if anyone in your family has been diagnosed or treated for any of the following, and explain relationship to you:

	Check if Yes:	**Relationship:**
Bipolar disorder	____	_____________
Depression	____	_____________
Anxiety	____	_____________
Anger	____	_____________
Suicide/Suicide attempt	____	_____________
Schizophrenia	____	_____________
Post-traumatic stress	____	_____________
Alcohol abuse	____	_____________
Other substance abuse	____	_____________
Violence	____	_____________
Other______________	____	_____________

Relationship Status

□ Single □ Married □ Living with partner □ Separated/Divorced
□ Widowed □ In a relationship □ Other______________________

Have you ever been in an abusive relationship? □ Yes □ No
If so, what was your role in the abuse? □ Victim □ Abuser □ Both
What kind of abuse? □ emotional □ physical □ sexual □ other__________
Are you currently in an abusive relationship? □ Yes □ No
Do you feel safe? □ Yes □ No
Comments about past/present relationship(s) (optional):_____________________________

____

____

____

Mental Health History

Please check all of the items below that describe your situation:

____ Abuse/trauma – physical, sexual, emotional, neglect
____ Aggression, violence
____ Alcohol use
____ Anger, hostility, arguing, irritability
____ Anxiety, nervousness
____ Attention, concentration, distractibility
____ Career concerns, goals, and choices
____ Childhood issues
____ Codependence
____ Confusion
____ Compulsions and/or obsessions (thoughts or actions that repeat themselves)
____ Decision-making, indecision, mixed feelings, putting off decisions
____ Delusions (false ideas)
____ Dependence
____ Depression, low mood, sadness, crying
____ Divorce, separation, marital conflict, infidelity/affairs
____ Drug use – prescription medications, over-the-counter medications, street drugs
____ Eating problems – overeating, undereating, appetite, vomiting
____ Emptiness
____ Failure
____ Fatigue, tiredness, low energy
____ Fears, phobias
____ Financial or money troubles, debt, impulsive spending, low income
____ Gambling
____ Grieving, mourning, deaths, losses, divorce
____ Guilt
____ Headaches, other kinds of pains
____ Health, illness, medical concerns, physical problems
____ Inferiority feelings
____ Impulsiveness, loss of control, outbursts
____ Irresponsibility
____ Judgment problems, risk taking
____ Legal matters, charges, suits
____ Loneliness
____ Memory problems
____ Mood swings
____ Oversensitivity to rejection
____ Panic or anxiety attacks
____ Perfectionism
____ Pessimism
____ Procrastination, lack of motivation
____ Relationships problems (with friends, with relatives, or at work)
____ School problems
____ Self-centeredness
____ Self-esteem
____ Self-neglect, poor self-care

____ Sexual issues, dysfunctions, conflicts, identity issues
____ Sleep problems (too much, too little, insomnia, nightmares)
____ Spiritual, religious, moral, ethical issues
____ Stress and tension
____ Suspiciousness/ Paranoia
____ Suicidal thoughts
____ Temper problems, self-control, low frustration tolerance
____ Thought disorganization and confusion
____ Threats, violence
____ Weight and diet issues
____ Withdrawal, isolation
____ Work problems, employment issues
____ Other____

Please describe any major losses or traumas you have experienced:

____
____
____

What significant life changes or stressful events have you experienced recently?

____
____
____

Please check the levels of mental health treatment that you have engaged in during your lifetime:

If checked, please indicate approximate timeframe and reason for treatment:

Residential treatment/Hospitalization ______________________________
Partial Hospitalization treatment ______________________________
Intensive Outpatient treatment ______________________________
Outpatient treatment ______________________________

Suicide Risk Assessment

Have you ever had any suicidal thoughts or wish you could go to sleep and not wake up? □ Yes □ No
If yes, have you had these thoughts in the past month? □ Yes □ No
Have you had thoughts about killing yourself with a plan? □ Yes □ No
If yes, please describe____
Have you had these thoughts in the past month? □ Yes □ No
Are you currently experiencing suicidal ideation? □ Yes □ No
If yes, have you started to work out or worked out the details of how to kill yourself? □ Yes □ No
Do you intend to carry out this plan? □ Yes □ No
Please describe____
What is the single, most important aspect or person in your life worth living for? ____________
____

Educational History

Highest Grade Completed? ___________ **Where?**___________________________________
Did you attend college? _________ **Where?** _______________________________________
Major? ____
What is your highest educational level or degree attained?
____

Occupational History

Are you currently: □ Working □ Student □ Unemployed □ Disabled □ Retired
How long in current position? ____
What is/was your occupation? ____
Where do you work? ____
Have you ever served in the military? □ Yes □ No
If yes, what branch and when? ____________________________
Honorable discharge? □ Yes □ No **Other type discharge**______________________________

Legal History

Have you ever been arrested? □ Yes □ No
If yes, when?_____________ **Reason:**____
Do you have any pending legal charges? □ Yes □ No
Are you currently on Parole or Probation? □ Yes □ No
If yes, until when?____

Cultural and Spiritual Life

Please list any cultural, spiritual, or religious groups you identify with: ________________
____
Do any of the above listed serve as a support or coping mechanism for you? □ Yes □ No
Do you need help coping with any cultural, religious, or spiritual aspect in your life?
□ Yes □ No **If yes, please describe:**____
____

Is there anything else you would like your therapist to know about you and/or your unique therapeutic needs?____
____
____
____
____
____

Thank you for taking the time to answer the above questions, these will help your therapist get a better idea of your individual therapeutic needs.