Intake Form

Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information. You can fill out this form ahead of time and bring it to your first session.

Name:____

(Last) (First) (Middle Initial)

Birth Date: _______ /_______ /_______ Age: _________

Gender: ☐ Female ☐ Male ☐ Non-binary/ third gender ☐ Prefer to self-describe ___________________ ☐ Prefer not to say

Do you identify as transgender? ☐ Yes ☐ No ☐ Prefer not to say

What is your Sexual Orientation? ☐ Straight/Heterosexual ☐ Gay or Lesbian

☐ Bisexual ☐ Prefer to self-describe __________________ ☐ Prefer not to say

Race/Ethnicity: ____

Relationship Status:

□ Never Married □ Domestic Partnership □ Married □ Separated □ Divorced

□ Widowed

Please list any children/ages:

____

Referred by (if applicable):

____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)? □ No □ Yes,

previous therapist/practitioner(s) and dates:

____

____

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:

   ____

   ____

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 do 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? □ No □ Yes

If yes, on average how many days do you drink each week? __________

Approximate number of drinks each time you drink:_________________

9. How often do you engage 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	List Family Member
Alcohol/Substance Abuse	yes/no	
Anxiety	yes/no	
Depression	yes/no	
Domestic Violence	yes/no	
Eating Disorders	yes/no	
Obsessive Compulsive Behavior	yes/no	
Schizophrenia	yes/no	
Suicide Attempts	yes/no	
Other		

ADDITIONAL INFORMATION:

1. Are you currently employed or in school? □ No □ Yes
   If yes, what is your current employment/school situation:
   ____

   Do you enjoy your work or school? Is there anything stressful about your current work or school situation?
   ____
   ____

What is your highest level of education?____________________________

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 out of your time in therapy?
   ____
   ____
   ____
   ____
   ____