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INTAKE INFORMATION

Information you provide here is held to the same standards of confidentiality as our therapy. Please leave blank any questions you prefer not to answer.

Name: _____
(Last) (First) (Middle Initial)

Name of parent/guardian (if you are a minor):
_____
(Last) (First) (Middle Initial)

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

Marital Status:
□ Never Married □ Partnered □ Married □ Separated □ Divorced □ Widowed

Number of Children: _____

Local 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

Referred by: _____

Are you currently receiving psychiatric services, professional counseling or psychotherapy elsewhere? □ Yes □ No

Have you had previous psychotherapy? □No □Yes
Previous therapist's name _____

Are you currently taking prescribed psychiatric medication (antidepressants or others)?
□Yes □No If Yes, please list: _____
If no, have you been previously prescribed psychiatric medication?
□Yes □No If Yes, please list: _____

HEALTH AND SOCIAL INFORMATION

1. How is your physical health at present? (please circle)
Poor Unsatisfactory Satisfactory Good Very good

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

3. Are you having any problems with your sleep habits? □ No □ Yes
If yes, check where applicable:
□ Sleeping too little □ Sleeping too much □ Poor quality sleep □ Disturbing dreams
□ Other _____

4. How many times per week do you exercise? _____
Approximately how long each time? _____

5. Are you having any difficulty with appetite or eating habits? □ No □ Yes
If yes, check where applicable: □ Eating less □ Eating more □ Binging □ Restricting
Have you experienced significant weight change in the last 2 months? □ No □ Yes

6. Substance Abuse Screen
What is your use history for the following drugs?
Alcohol..... □Never used □Never had a problem □Current problem □Past history of a problem
Heroin..... □Never used □Never had a problem □Current problem □Past history of a problem
Cocaine..... □Never used □Never had a problem □Current problem □Past history of a problem
Marijuana ..... □Never used □Never had a problem □Current problem □Past history of a problem
Amphetamines..... □Never used □Never had a problem □Current problem □Past history of a problem
Tranquilizers ..... □Never used □Never had a problem □Current problem □Past history of a problem

Are you abusing, or have a history of abusing, any other drugs (including prescription drugs)?
□ No □Yes

Have you ever participated in substance abuse treatment or support groups?
□ No □Yes

7. Do you have family members or significant others who have alcohol or other drug abuse problems?
□ No □Yes

8. Have you had suicidal thoughts recently? □ Frequently □ Sometimes □ Rarely □ Never
Have you had them in the past? □ Frequently □ Sometimes □ Rarely □ Never

9. In the last year, have you experienced any significant life changes or stressors:
_____
_____

Are you currently experiencing any of the following symptoms or problems?

Depressed mood	□ No □ Yes
Mood Swings	□ No □ Yes
Rapid Speech	□ No □ Yes
Anxiety/Nervousness	□ No □ Yes
Panic Attacks	□ No □ Yes
Phobias	□ No □ Yes
Grief/Bereavement	□ No □ Yes
History of Abuse/Trauma	□ No □ Yes
Hallucinations	□ No □ Yes
Unexplained losses of time	□ No □ Yes
Unexplained memory lapses	□ No □ Yes
Frequent Illness	□ No □ Yes
Eating Disorder	□ No □ Yes
Body Image Problems	□ No □ Yes
Lack of Motivation	□ No □ Yes
Repetitive Thoughts (e.g., Obsessions)	□ No □ Yes
Repetitive Behaviors (e.g., Frequent Hand-Washing)	□ No □ Yes
Homicidal Thoughts	□ No □ Yes
Suicide Attempt	□ No □ Yes
Low self-confidence	□ No □ Yes
Feelings of Hopelessness	□ No □ Yes
Marital Problems	□ No □ Yes
Parent/Child Conflicts	□ No □ Yes
Academic/School Problems	□ No □ Yes
Career/Job Problems	□ No □ Yes
Sexuality Problems	□ No □ Yes
Intimacy Problems	□ No □ Yes
Legal Problems	□ No □ Yes
Self-harm	□ No □ Yes

Other_____

OCCUPATIONAL INFORMATION:

Are you currently employed? □ No □ Yes
If yes, who is your current employer/position? _____
If yes, are you happy at your current position? _____
Please list any work-related stressors, if any: _____
_____

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.):

Difficulty	**Family Member**
Depression: □ No □ Yes	_____
Bipolar Disorder: □ No □ Yes	_____
Anxiety Disorders: □ No □ Yes	_____
Panic Attacks: □ No □ Yes	_____
Schizophrenia: □ No □ Yes	_____
Alcohol/Substance Abuse: □ No □ Yes	_____
Eating Disorders: □ No □ Yes	_____
Learning Disabilities: □ No □ Yes	_____
Trauma History: □ No □ Yes	_____
Suicide Attempts: □ No □ Yes	_____

OTHER INFORMATION:

What do you consider to be your strengths? _____
_____
_____
_____

What do you like most about yourself? _____
_____
_____

What are effective coping strategies that you've learned? _____
_____
_____

What are your goals for therapy? _____
_____
_____