General Intake Form

Please provide the following information. Leave blank any question you would rather not answer. Information you provide here is held to the same standards of confidentiality as our therapy. Bring this form to your first session or allow yourself thirty minutes prior to your appointment to complete the form.

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
*Please be aware that email might not be confidential.

Referred by: _____

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

Have you had previous psychotherapy? □No □Yes, at 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. Do you regularly use alcohol? □ No □ Yes

In a typical month, how often do you have 4 or more drinks in a 24-hour period?

_____

7. How often do you engage in recreational drug use?

□ Daily □ Weekly □ Monthly □ Rarely □ Never

8. Have you had suicidal thoughts recently? □ Frequently □ Sometimes □ Rarely □ Never

Have you had them in the past? □ Frequently □ Sometimes □ Rarely □ Never

9. Are you currently in a romantic relationship? □ No □ Yes If yes, how long have you been in this relationship? _____

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

10. In the last year, have you experienced any significant life changes or stressors?

_____

_____

Have you ever experienced:

Extreme depressed mood: □ No □ Yes
Rapid Speech: □ No □ Yes
Panic Attacks: □ No □ Yes
Sleep Disturbances: □ No □ Yes
Unexplained losses of time: □ No □ Yes
Alcohol/Substance Abuse: □ No □ Yes
Eating Disorder: □ No □ Yes
Repetitive Thoughts: □ No □ Yes
Homicidal Thoughts: □ No □ Yes

Wild Mood Swings: □ No □ Yes
Extreme Anxiety: □ No □ Yes
Phobias: □ No □ Yes
Hallucinations: □ No □ Yes
Unexplained memory lapses: □ No □ Yes
Frequent Body Complaints: □ No □ Yes
Body Image Problems: □ No □ Yes
Repetitive Behaviors: □ No □ Yes
Suicide Attempt: □ No □ Yes

OCCUPATIONAL INFORMATION:

Are you currently employed? □ No □ Yes If yes, who is your current employer/position?

_____

Please list any work-related stressors, if any: _____

Demographic

Your complete name:_____

Address:_____

City:_____ **State:**_____ **Zip Code**_____

Phone number:_____ **cell or hm**

Age:_____ **SSN#**_____ **Race:**_____

D.O.B._____ **Birthplace:**_____

Education (last grade completed and postsecondary):_____

Are you employed? ☐ Yes ☐ No Current Occupation: _____

Current driver's license: ☐ Yes ☐ No Eligible to drive: ☐ Yes ☐ No

Reliable Vehicle: ☐ Yes ☐ No

Religion: _____

Person to alert in the event of medical emergency:_____

Relationship to you:_____ **Phone:**_____

Family Doctor: Name/Phone:_____

Status (circle one): Single Married Partnered Separated Divorced Widowed

Spouse/partner's 1st name:_____ **Age:**_____

Yrs in relationship:_____

Living Arrangement (circle one): Alone Spouse/Partner With Family With Friends

Other:_____ **How long at your address:** _____

Children (gender, age):_____

_____

Monthly Income: Less than $200 $200-$500 $600-$1000 Over $1000

SASSI _____ DAST _____ NDP_____

Please describe any significant current or past medical problems:_____

_____

_____

Have you ever had any STD's: ☐ Yes ☐ No _____

Please list any medications you currently take. Include prescription and over-the-counter medications and the dosage of each.

_____

_____

_____

_____

Have you had previous psychological care or counseling? ☐ Yes ☐ No

If yes, please give the name of the clinician(s), the months you saw them (e.g., Nov 06 - Feb 07), and the nature of the difficulty at the time.

_____

_____

_____

_____

Have you ever been hospitalized for a psychological difficulty? ☐ Yes ☐ No

If yes, please give the dates and the nature of the difficulty at the time:

_____

_____

_____

_____

Drug/Alcohol Use: (Place an "X" next to the drug item, what age of first use, and list how many year total using that drug.)

_____ **Marijuana Age_____ How many years?_____**

_____ **Amphetamines/Methamphetamines Age_____ How many years?_____**

_____ **Crack/Cocaine Age_____ How many years?_____**

_____ **Heroin Age_____ How many years?_____**

_____ **LSD Age_____ How many years?_____**

_____ **Ecstasy Age_____ How many years?_____**

_____ **Mushrooms Age_____ How many years?_____**

_____ **PCP Age_____ How many years?_____**

_____ **Alcohol Age_____ How many years?_____**

****How many times a week?_____**

_____ **Illegal Prescription Drugs Age_____ How many years? _____**

****List pills_____**

_____

_____ **Synthetics Age_____ How many years?_____**

****List synthetics (Ex. K2, Bath Salts, etc.)_____**

_____

_____

Do you use tobacco? If so, what kind_____

How often?_____ How many years?_____

Have you ever been in rehab/detox? ☐ Yes ☐ No

If yes, please give the location:

_____

_____

_____

Are you awaiting sentencing, court, trial, etc.? If so, explain:_____

_____

_____

Are you currently on probation/parole? ☐ Yes ☐ No If so, Probation Officer's Name:_____ **Cause #** _____

If yes, please list the county, charge and year of the probation/parole:_____

_____

***How many positive UA's:**_____ **what drug(s):**_____

Do you owe court/restitution/legal cost: ☐ Yes ☐ No _____

_____

Have you been in jail in the last 30 days ☐ Yes ☐ No

Have you been on probation in the past: ☐ Yes ☐ No _____

_____

List (ALL) previous charges/past convictions: _____

_____

_____

Do you have an open Child Protection Service (CPS) cases? ☐ Yes ☐ No

If so, briefly, explain:_____

_____

_____

***How many positive UA's:**_____ **what drug(s):**_____

Have you ever been abused (physically, verbally, sexually, emotional): Y or N

If so, by whom:_____

For Office Use Only: (Recommendations, Follow-up Note)

_____

_____

_____

_____

_____

Emailed on date/time:

_____

_____