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 or email it to moorek430@gmail.com

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

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

_____
(Last) (First) (Middle Initial)

Birth Date: _____/_____/_____ Age: _____ Gender: _____

Marital Status:

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

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): _____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

□ No

□ Yes, previous therapist/practitioner:

_____

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:

_____

GENEREAL 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 to 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 more than once a week? □ No □ Yes

9. How often do you engage recreational drug use?

□ Daily □ Weekly □ Infrequently □ Monthly □ 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	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 Behaviors	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?

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2. Do you consider yourself to be spiritual or religious?

□ No □ Yes

If yes, describe your faith or belief:

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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?

_____

_____

_____

_____