

INTAKE FORM

Please note that information provided is confidential.
Please fill out this form and bring it to your first session.

Name: _____

Name of Parent/Guardian (if you are under the age of 18)

Address: _____

City: _____ Postal code: _____

RES #: _____ May I leave a message? Yes/No

Work #: _____ May I leave a message? Yes/No

Mobile #: _____ May I leave a message? Yes/No

Email address (Email correspondence is not considered a confidential method of communication): _____

May I email you? _____

Occupation: _____

Age: _____ Birthdate: _____

Marital Status: (please circle)

Never Married Cohabiting Married Separate Divorced Widowed

List the name(s) of children with their age and gender:

Emergency Contact Name and Number

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

If yes, when and for how long? Name of previous therapist:

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 when prescribed:

Indicate if there is a family history of any of the following. If yes, please indicate the family member's relationship to you.

Alcohol/Substance Abuse: No/Yes _____

Anxiety: No/Yes _____

Depression: No/Yes _____

Eating Disorders: No/Yes _____

Schizophrenia: No/Yes _____

Suicide Attempts: No/Yes _____

Circle any of the following that may apply to you:

Headaches Inferiority feelings Shy with people Dizziness Feel tense

Can't make friends Fainting spells Feel panicky Afraid of people No appetite

Fears and phobias Poor home conditions Over-eating Obsessions

Unable to enjoy yourself Stomach trouble Depressed Always worried

Suicidal feelings Often tired Need for tranquilizers Alcoholism Overambitious

Unable to relax Drug use Financial problems Insomnia Gambling

Recurrent dreams Job problems Nightmares Hallucinations Sexual problems

How would you rate your current physical health? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Name of your physician: _____

When was your last check up? _____

Please list any specific health problems you are currently experiencing:

How is your mood? Are you experiencing sadness, grief, or depression?

Yes/No

If yes, for approximately how long?

Are you currently experiencing anxiety? No Yes

If yes, when did you begin experiencing this?

Do you drink alcohol? If yes, how much?

Do you use recreational drugs? If so, what kind and how often?

Are you currently in a romantic relationship?

Yes/No

If yes, for how long? _____

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

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

Do you enjoy your work? Is there anything stressful about your current work?

Do you have any spiritual or cultural affiliations? Yes/No If yes, please describe

What do you consider to be some of your strengths?

What do you consider to be some of your weaknesses?

What brings you to therapy and what would you like to accomplish?

Signature _____

Date _____

