



## Intake Form

Please take your time in providing the following information. The questions are designed to help me begin to understand you so that our time together can be as productive as possible. All information provided is confidential.

Name: \_\_\_\_\_  
(Last) (First) (Middle Initial)

Name of parent/guardian (if under 18 years): \_\_\_\_\_  
(Last) (First) (Middle Initial)

Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_ Gender: Male Female

Social Security Number: \_\_\_\_\_

Occupation: \_\_\_\_\_

**Have you previously received any type of mental health services?**

Yes

No

If yes, which of the following:

Psychotherapy

Medication

Outpatient Hospitalizations/ Inpatient Hospitalizations

If yes, please provide:

Name of provider or facility: \_\_\_\_\_

Location: \_\_\_\_\_

Dates of treatment: \_\_\_\_\_

Reason for treatment: \_\_\_\_\_

**Briefly, what brings you in today**

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**When did your problem first start? Within the last:**

30 days

6-12 months

2 years

During adolescence

During childhood

**What areas of your life have been impacted because of this problem?**

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**Are you currently experiencing overwhelming sadness, grief or depression?**

Yes

No

**If yes, for approximately how long?**

**Are you currently experiencing anxiety, panic attacks or have any phobias?**

Yes

No

If yes, when did you begin experiencing this?

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Please describe any major losses or traumas you have experienced:

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

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**What would you like to accomplish out of your time in therapy?**

1. \_\_\_\_\_

2. \_\_\_\_\_



3. \_\_\_\_\_

**Family History**

Please list your parents and siblings. Please use additional space on the back if needed

Name	Age	Relationship	Where do they live now?	If deceased, age and cause of death

Who did you live with while growing up? \_\_\_\_\_

**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.).**

Condition	Please circle	List Family Member
Alcohol/Substance Abuse	yes/no	
Anxiety	yes/no	
Depression	yes/no	
Domestic Violence	yes/no	
Sexual Abuse	yes/no	



Eating Disorders	yes/no	
Obesity	yes/no	
Obsessive Compulsive Disorder	yes/no	
Schizophrenia	yes/no	
Suicide Attempts	yes/no	
Other diagnosed mental health condition?	yes/no: which was---	

**Marital Status:** Never Married    Domestic Partner    Married    Separated

**Divorced** -- For how long? \_\_\_\_\_

**Widowed:** Please provide your partners name and year deceased:

\_\_\_\_\_

If married, how long have you been married for and what is your partners name:

\_\_\_\_\_

**Are you currently in a romantic relationship?** Yes No

On a scale of 1-10 (best), how would you rate your relationship? \_\_\_\_\_

**Please list any children, their names, and ages:** \_\_\_\_\_

\_\_\_\_\_

**Physical Health:**

Please list any medications, herbs, or supplements. Be sure to include the condition, as some medications are prescribed for off-label use. Continue on the back if needed, or provide a separate list. If you have a complicated medical profile, please supply supporting documentation to be able to facilitate a comprehensive understanding of your health.

Medication/ Supplement	Dosage	Condition	Date Began/Stopped




**Prescribing provider and contact information:**

Name:

Phone, email, or Fax:

**How would you rate your current physical health?**

Poor Unsatisfactory Satisfactory Good Very Good

Please list any specific health problems you are currently experiencing:

**How would you rate your current sleeping habits?**

Poor Unsatisfactory Satisfactory Good Very Good

If you are having problems, in which phase of sleep are you experiencing issues?

**How many times per week do you generally exercise?** \_\_\_\_\_

What types of exercise do you participate in: \_\_\_\_\_

**Are you currently experiencing any chronic pain?** Yes No

If yes, please describe:

\_\_\_\_\_  
Please describe *current* use of alcohol, cigarettes, and/or recreational drugs:

\_\_\_\_\_  
Please describe *previous* use of alcohol, cigarettes, and/or recreational drugs:

**Additional Information:**

What do you enjoy about your work (full-time homemaker included)? If retired, what did you enjoy about your work?

\_\_\_\_\_  
What do you find particularly stressful about your current or previous work?

\_\_\_\_\_  
What do you enjoy doing in your free time? What do you do to relax?



Do you consider yourself to be spiritual or religious? If yes, please describe your faith or belief:

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What do you consider to be some of your strengths?

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What do you consider to be some of your weakness?

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Printed Name

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Signature

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Date