INTAKE FORM

- Please print out and complete this form and bring it with you to your first session.
- Also, bring a government issued photo identification to your first session.
- Please provide the following information.
- Information that you provide is confidential.

NAME:

_____ _____ _____
(Last Name) (First Name) (Middle Name)

BIRTH DATE: **AGE:** **GENDER:**

_____ / _____ / _____ _____ ☐ Male ☐ Female
(Month) (Day) (Year)

MARITAL STATUS:

☐ Never Married ☐ Separated
☐ Domestic Partner ☐ Divorced
☐ Married ☐ Widowed

CHILDREN & THEIR AGE:

_____

ADDRESS:

_____
(Street and Number)

_____ _____ _____
(City) (State) (Zip Code)

HOME PHONE: **CELL PHONE:** **EMAIL:**

_____ _____ _____
May I leave a message? May I leave a message? May I email you?
☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No

What is your preferred method of communication? _____

WERE YOU REFERRED BY SOMEONE? IF SO, WHO?

_____

HAVE YOU PREVIOUSLY RECEIVED ANY TYPE OF MENTAL HEALTH SERVICES? (such as: psychological, psychiatric, counseling, etc)

☐ Yes ☐ No

LIST PREVIOUS THERAPISTS (OR DOCTORS) AND TREATMENT RECEIVED:

_____

_____

ARE YOU CURRENTLY PRESCRIBED ANY PSYCHIATRIC MEDICATION:

☐ Yes ☐ No

Medication: _____ Dose: _____ Prescriber:_____
Medication: _____ Dose: _____ Prescriber:_____
Medication: _____ Dose: _____ Prescriber:_____

ARE YOU TAKING ANY MEDICATIONS OF ANY KIND? LIST:

_____

ARE YOU TAKING ANY VITAMINS, MINERALS, HERBS ETC? LIST:

_____

GENERAL & MENTAL HEALTH

HOW WOULD YOU RATE YOUR CURRENT <u>PHYSICAL</u> HEALTH:

☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Excellent

Please list any physical symptoms and diagnoses:

_____

HOW WOULD YOU RATE YOUR CURRENT <u>COGNITIVE</u> HEALTH:

☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Excellent

Please list any physical symptoms and diagnoses:

_____

HOW WOULD YOU RATE YOUR CURRENT <u>EMOTIONAL</u> HEALTH:

☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Excellent

Please list any physical symptoms and diagnoses:

_____

HOW WOULD YOU RATE YOUR CURRENT <u>QUALITY OF SLEEP</u>:

☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Excellent

Are you experiencing any of the following:

☐ Difficulty falling asleep?
☐ Difficulty staying asleep?
☐ Nightmares?
☐ Night Terrors?

HOW WOULD YOU RATE YOUR CURRENT <u>APPETITE</u>:

☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Excellent

Any recent weight gain? ☐ Yes ☐ No
Any recent weight loss? ☐ Yes ☐ No
Any GI issues? ☐ Yes ☐ No

HOW WOULD YOU RATE YOUR CURRENT <u>LIBIDO</u>:

☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Excellent

HOW WOULD YOU RATE YOUR CURRENT <u>ATTENTION & CONCENTRATION</u>:

☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Excellent

HOW WOULD YOU RATE YOUR CURRENT <u>ABILITY TO BE MINDFUL</u>:

☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Excellent

HOW WOULD YOU RATE YOUR CURRENT <u>QUALITY OF SLEEP</u>:

☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Excellent

HOW WOULD YOU RATE YOUR ABILITY TO REMAIN PRESENT IN THE MOMENT:

☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Excellent

HOW WOULD YOU RATE YOUR ENERGY LEVELS:

☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Excellent

WOULD YOU CONSIDER YOURSELF:

☐ Physically restless ☐ Uneasy

☐ Fidgety ☐ Without purpose

ARE YOU CURRENTLY EXPERIENCING OVERWHELMING GRIEF, SADNESS, DEPRESSION?

☐ Yes ☐ No (If yes, for how long? _____)

ARE YOU CURRENTLY EXPERIENCING OVERWHELMING ANXIETY, PANIC ATTACKS, PHOBIAS?

☐ Yes ☐ No (If yes, for how long? _____)

ARE YOU CURRENTLY EXPERIENCING OVERWHELMING WORRY, RACING THOUGHTS, CONTINUOUS THOUGHTS?

☐ Yes ☐ No (If yes, for how long? _____)

ARE YOU CURRENTLY EXPERIENCING ANY PHYSICAL PAIN?

☐ Yes ☐ No

If yes, for how long? _____)

Type and location of pain: _____)

Intensity of pain on scale of 1 to 10: _____)

HOW OFTEN DO YOU EXERCISE?

_____

HOW OFTEN DO YOU MEDITATE?

_____

HOW MANY LITERS OF WATER DO YOU DRINK PER DAY?

_____

HOW OFTEN DO YOU SPEND TIME OUTDOORS?

_____

HOW OFTEN ARE YOU LEARNING OR DOING NEW THINGS?

_____

HOW OFTEN DO YOU USE:

Alcohol?	Cigarettes?	Marijuana?	Recreational drugs of any type?
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
How often?	How often?	How often?	If yes, which??
_____	_____	_____	_____

Do you use any other form of drug to escape or numb emotional pain?
☐ Yes ☐ No

If so, which?

_____

ARE YOU CURRENTLY IN A ROMANTIC RELATIONSHIP? ☐ Yes ☐ No
On a scale of 1-10, how would your rate your current relationship? _____

ARE YOU CURRENTLY EXPERIENCING ANY SIGNIFICANT LIFE SITUATIONS, LIFE CHANGES, OR STRESSORS?

_____

_____

_____

_____

FAMILY MENTAL / EMOTIONAL HEALTH HISTORY
Has anybody in your family experienced any of the following conditions?

Anxiety:	☐ Yes	☐ No	Relationship: _____
Depression:	☐ Yes	☐ No	Relationship: _____
Substance Abuse:	☐ Yes	☐ No	Relationship: _____

Suicide Attempts:	☐ Yes	☐ No	Relationship: _____
Mental Disorder:	☐ Yes	☐ No	Relationship: _____
Dementia:	☐ Yes	☐ No	Relationship: _____
Violence:	☐ Yes	☐ No	Relationship: _____

List any other family history:

_____

_____

ADDITIONAL INFORMATION:

HIGHEST EDUCATION LEVEL COMPLETED:

_____

ARE YOU CURRENTLY EMPLOYED?

☐ Yes ☐ No

If yes, what is your profession? _____

DO YOU FEEL THAT YOUR CURRENT EMPLOYMENT/ WORK IS REWARDING?

☐ Yes ☐ No

ARE YOU A SPIRITUAL OR RELIGIOUS PRACTITIONER?

☐ Spiritual ☐ Religious ☐ Both ☐ None

If yes, please describe your belief, faith, or practices?

_____

_____

WHAT WOULD YOU SAY ARE YOUR STRENGTHS?

_____

_____

WHAT WOULD YOU LIKE TO ACCOMPLISH THROUGH THERAPY?

_____

_____

_____

ADDITIONAL NOTES: