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INTAKE FORM

Please provide the following information and answer the questions below. Please note: information you provide here is confidential and protected.

Please fill out this form and bring it to your first session.

Date _____ First Name _____ Last Name _____

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

Address _____

City _____ State _____ Zip _____

Home or Cell Phone _____ OK to contact you here? □ Yes □ No

Email _____ OK to contact you here? □ Yes □ No
*Please note: Email correspondence is not considered to be a confidential medium of communication.

Whom may I thank for referring you to me (please name):_____

1. Briefly describe the issues/concerns that have brought you here _____

_____

_____

2. Please check any of the following struggles that still pertain to you:

__Anxiety	__Depression	__Fears/Phobias	__Eating Disorders
__Sexual Problems	__Suicidal Thoughts	__Separation/Divorce	__Relationships
__Finances	__Drug/Alcohol Use	__Career Choices	__Anger
__Self-Control	__Unhappiness	__Insomnia	__Religious Matters
__Work/Stress	__Health Problems	__Cutting/Self-Mutilation	__Thought Patterns

3. What significant life changes or stressful events have you experienced recently:

_____

_____

4. Please list any specific health problems you are currently experiencing:

_____

5. How would you rate your current sleeping habits?
□ Poor □ Unsatisfactory □ Satisfactory □ Good □ Very good

Please list any specific sleep problems you are currently experiencing: _____

_____

6. Are you currently experiencing overwhelming sadness, grief or depression? □ No □ Yes

If yes, for approximately how long? _____

7. Are you currently experiencing anxiety, panic attacks or have any phobias? □ No □ Yes

If yes, when did you begin experiencing this? _____

8. Are you currently taking any medication? □ No □ Yes

If yes, please explain/describe _____

_____

9. Do you drink alcohol more than once a week? □ No □ Yes

10. Do you binge-drink or are you concerned about your use of alcohol? □ No □ Yes □ Not sure

11. How often do you engage recreational drug use?
□ Daily □ Weekly □ Monthly □ Infrequently □ Never

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

If yes, please give the name, date, and location of the therapy and briefly explain the nature of the

problem which required attention: _____

_____

13. Are you currently in a romantic relationship? □ Yes □ No (If no, stop here)

If yes, for how long? _____

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

14. Do you feel anxious or nervous when you are around your partner?
□ No □ Sometimes □ Regularly

15. Does your partner keep you from going out or doing things that you want to do?
□ No □ Sometimes □ Regularly

16. Does your partner say that if you try to leave him or her, you will never see your children again?
□ No □ Sometimes □ Not applicable