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INTAKE FORM

Date: _____
Name: _____ Preferred pronouns: _____
Address: _____
_____
Email: _____ Can I leave msgs at this address? Yes / No
Cell#: _____ Can I leave msgs at this number? Yes / No
Employer/Occupation _____ Who referred you? _____

AREAS OF CONCERN:

What concerns motivated you to seek therapy? _____
_____
When did these problems begin? _____
Are they getting better, worse or remaining the same? _____
What are your therapy goals? _____
_____

PERSONAL & FAMILY HISTORY:

Where were you born and/or grow up?_____
Did you experience any developmental, academic or behavior problems as a child? Yes / No
If yes, please explain: _____
What is your highest level of education? _____

Did your parent's divorce? Yes___ No___ If yes, how old were you when they divorced?_____
Number of siblings: Sisters (biological) _____ (adopted) _____ (stepsisters) _____
Brothers (biological) _____ (adopted) _____ (stepbrothers) _____

Were you the oldest, youngest, middle, or only child in your family? _____

Would you describe your childhood as (circle):
good bad traumatic happy sad stable lonely scary safe chaotic

When you were a child, did you ever suffer from physical, sexual, verbal or mental abuse? Yes / No
If yes, please briefly explain here or on an additional page - who, what kind, how old were you, etc.
_____
_____

Are you currently married/in a long-term relationship(s)? Yes / No If yes, for how long _____
Current spouse/partner(s):
Name _____ Age _____ Education _____ Occupation _____
Name _____ Age _____ Education _____ Occupation _____
Name _____ Age _____ Education _____ Occupation _____

If you have children, please list names & ages: _____, _____, _____, _____
Who lives in your household?

_____

Do you identify by any labels? For ex. non-binary, queer, heterosexual cis, etc.

_____

DRUG & ALCOHOL HISTORY:

How much alcohol do you consume? _____ drinks per day/week (please circle)
Do you use any recreational drugs? Yes / No If yes, what substance? _____
Do you currently smoke cigarettes? Yes / No How many per day? _____
Have you had treatment for alcohol or drugs? Yes / No (If yes, please detail on an additional page.)

MEDICAL & PSYCHOLOGICAL HISTORY:

Name/phone # of Primary Care Physician (if you have one): _____
Do you want me to coordinate your care with your PCP? Yes / No
(Please note, if yes, we will need to discuss signing a release of information as well as other matters.)

Please list any chronic medical illnesses (asthma, high blood pressure, diabetes, seizures, etc.):

_____

Have you been in counseling / therapy in the past?_ Yes / No If yes, when & for what?

_____

_____ _____

Have you ever been hospitalized for medical/psychiatric reasons? Yes / No
If yes, please detail on another page.

Name/phone # of current Psychiatrist (if you have one): _____

Please list all current medications you are taking (give names & dosages):
Name: _____ (____mg) Name: _____ (___mg)
Name: _____ (____mg) Name: _____ (___mg)

Please describe any major health, medical or mental health problems among family members:
Father _____ Mother _____
Brothers _____ Sisters _____
Children _____ Grandparents _____
Is your father alive? Yes___ No___ Is your mother alive? Yes___ No___

ACTIVITIES OF DAILY LIVING: Please describe a typical day for you

Morning:_____ Do you eat Breakfast? Yes / No
Noon: _____ Lunch? Yes / No
Evening: _____ Dinner? Yes / No
What do you do for fun? (Hobbies & interests):

_____

How would you rate your sleep?

_____

Do you exercise? Yes / No If yes, what kind and how often _____

_____

Are you less social than you used to be? Yes / No If yes, why?_____
Do you consider yourself introverted or extroverted? _____

SPIRITUAL / FAITH BACKGROUND:

How do you describe yourself? (circle):
Spiritual Religious Uncertain Agnostic Atheist Other_____
Spiritual affiliation(s): _____

PLEASE LIST SOURCES OF SUPPORT & STRENGTH IN YOUR LIFE:

_____

_____

Please add an additional page to share any other information you would like to share that is not covered on this form but may be relevant.

_____ ____/____/_____
Client Signature Date of Signature