**INTAKE FORM**

Please fill in the information below: Bring it along to your first session **OR** send it via email.

**Please note**: information provided on this form is protected as confidential information

**CLIENT INFORMATION**

**FULL NAME**:

**DATE OF BIRTH:**

**GENDER:**

**MARITAL STATUS:**

**EMPLOYMENT STATUS:**

**MILITARY STATUS:**

**EDUCATION:**

**ADDRESS:**

**TELEPHONE:**

**EMAIL:**

**EMERGENCY CONTACTS INFORMATION**

**EMERGENCY CONTACT NAME:**

**EMERGENCY CONTACT PHONE:**

**RELATIONSHIP TO CLIENT:**

**EMERGENCY CONTACT NAME:**

**EMERGENCY CONTACT PHONE:**

**RELATIONSHIP TO CLIENT:**

**TREATMENT HISTORY**

1. **Are you currently receiving psychiatric services, professional counseling or psychotherapy elsewhere?**

( ) No ( ) Yes

1. **Have you had previous psychotherapy?**

( ) No

( ) Yes, with (previous therapist’s name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Are you currently taking prescribed psychiatric medication (antidepressants or others?**

( ) No ( ) Yes

If yes, please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Prescribed by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HEALTH AND SOCIAL INFORMATION**

1. **Do you currently have a primary physician?**

( ) No

( ) Yes, who is it:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Are you currently seeing more than one medical health specialist?**

( ) No

( ) Yes, please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Please list below any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.**
2. **Are you currently on medication to manage a physical health concern?**

( ) No

( ) Yes, please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Are you having any problems with your sleep habits?**

( ) No ( ) If yes, check where applicable below:

( ) Sleeping too little ( ) Sleeping too much ( ) Poor quality sleep

( ) Disturbing dreams ( ) other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Are you having any difficulty with appetite or eating habits?**

( ) no

( ) If yes, check where applicable below:

( ) Eating less ( ) Eating more ( ) Bingeing ( ) Restricting

1. **Have you experienced significant weight change in the last 2 months**? ( ) no ( ) yes
2. **Do you regularly use alcohol?** ( ) no ( ) yes

In a typical month, how often do you have 4 or more drinks in a 24 hour period?

1. **How often do you engage recreational drug use?**

( ) daily ( ) weekly ( ) monthly ( ) rarely ( ) never

1. **Do you smoke cigarettes or use other tobacco products**? ( ) yes ( ) no
2. **Have you had suicidal thoughts recently?**

( ) frequently ( ) sometimes ( ) rarely ( ) never

**Have you had suicidal thoughts in the past?**

( ) frequently ( ) sometimes ( ) rarely ( ) never

1. **Are you currently in a romantic relationship?**

( ) no

( ) If yes, how long have you been in this relationship? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

On a scale of 1-10 (10 being the highest quality), how would you rate your current relationship?

In the last year, have you experienced any significant life changes or stressors? If yes, please explain**:**

1. **Have you ever experienced any of the following?**

|  |  |
| --- | --- |
| Extreme depressed mood | Yes / No |
| Dramatic mood swings | Yes / No |
| Rapid speech | Yes / No |
| Extreme anxiety | Yes / No |
| Panic attacks | Yes / No |
| Phobias | Yes / No |
| Sleep disturbances | Yes / No |
| Hallucinations | Yes / No |
| Unexplained losses of time | Yes / No |
| Unexplained memory lapses | Yes / No |
| Alcohol/substance abuse | Yes / No |
| Frequent body complaints | Yes / No |
| Eating disorder | Yes / No |
| Body image problems | Yes / No |
| Repetitive thoughts (e.g. obsessions) | Yes / No |
| Repetitive behaviors (e.g. frequent checking, hand washing | Yes / No |
| Homicidal thoughts | Yes / No |
| Suicidal attempts | Yes / No If yes, when? |

**OCCUPATIONAL INFORMATION**

**Are you currently employed**?

( ) no

( ) If yes, who is your currently employer/position? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If yes, are you happy with your current position? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please list any work-related stressors, if any:**

**RELIGIOUS/SPIRITUAL INFORMATION**

**Do you consider yourself to be religious?** ( ) no ( ) yes

If yes, what is your faith? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If no, do you consider yourself to be spiritual? ( ) no ( ) yes

**Please list any religious related stressors:**

**FAMILY MENTAL HEALTH HISTORY**

**Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following?** (Circle any that apply and list family member, e.g. sibling parent, uncle, etc.)

|  |  |  |
| --- | --- | --- |
| **Difficulty** | **Yes / No** | **Family member** |
| Depression | Yes / No |  |
| Bipolar disorder | Yes / No |  |
| Anxiety disorder | Yes / No |  |
| Panic attacks | Yes / No |  |
| Schizophrenia | Yes / No |  |
| Alcohol/substance abuse | Yes / No |  |
| Eating disorders | Yes / No |  |
| Learning disabilities | Yes / No |  |
| Trauma history | Yes / No |  |
| Suicide attempts | Yes / No |  |
| Chronic illness | Yes / No |  |
| Substance abuse |  |  |

**OTHER INFORMATION**

**What do you consider to be your strengths?**

**What do you like most about yourself?**

**What are effective coping strategies that you have learned?**

**What are your goals for therapy?**

*All forms will be reviewed during your intake session and the remaining time will be spent talking about what brought you in for counseling. We will then transition to hearing what reason/s led you to counseling, getting to know each other and determining if we are a good fit ,etc. You also will be provided information on the next step moving forward with your counseling needs, etc.*